



Fax Cover Sheet

To: Jose Cerda III

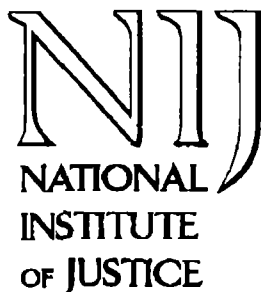
From: NATIONAL INSTITUTE OF JUSTICE

Re: Deficiencies Persist in Controlling Health Care Fraud

Date: February 2, 1999, 11:00 PM

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Washington, D.C.

NIJ "Fax" Sheets

Notice of New NIJ Publication Release

February 3, 1999

Deficiencies Persist in Controlling Health Care Fraud

Controlling criminal fraud is especially difficult in the health care industry due to a number of factors including faulty detection systems, ambiguous performance indicators, and a lack of adequate resources to deal with the problem. These are the findings of a study from the National Institute of Justice (NIJ) that examined the health care industry's methods of criminal fraud control and asked "Do they work?" and if not, "Why not?" The study assessed the assumptions, policies, and procedures comprising the health care industry's approach to criminal fraud control in an effort to understand strengths and weaknesses and to offer some ideas about how to make controls more effective.

The incidence of health care fraud remains at alarmingly high levels despite unprecedented attention in recent years from policymakers and law enforcement. Major scams appear to be artfully designed to circumvent routine controls and may remain invisible for long periods. This study concluded that when the scams are discovered, it is often more by luck than judgment.

Other factors that make criminal fraud control such a complex challenge:

- Maintaining effective fraud controls demands continuous assessment of emerging fraud trends and constant, rapid revision of controls.
- Too much reliance is placed on traditional enforcement approaches—effective investigations do not necessarily translate into effective control.
- The effectiveness of new fraud controls is routinely overestimated by those who put them in place.

This study was conducted by Malcolm K. Sparrow, Ph.D., Professor of Practice, at the John F. Kennedy School of Government, Harvard University.

For a copy of the Research in Brief *Fraud Control in the Health Care Industry: Assessing the State of the Art* (NCJ 172841, 11 pp.), call the National Criminal Justice Reference Service at 800-851-3420. The Research in Brief also references Dr. Sparrow's book which provides a more detailed account of his research on fraud. At this number you can also use the automated NCJRS Fax-on-Demand service to have a copy faxed directly (document 4043). You may download a copy of the report from the NIJ Web site at www.ojp.usdoj.gov/nij.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington, D.C. 20201

F A C S I M I L E

DATE: 2/9/99

TO: Chris Jennings

FAX#: 466-5557

FROM: Mary Beth Donahue
Chief of Staff

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

COMMENTS:

The following is gtr to the press release on
the medicine IG report.

 Pages [including this cover]

HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR IMMEDIATE RELEASE
Tuesday, Feb. 9, 1999

Contact: HCFA Press Office
(202) 690-6145

OIG Press Office
(202) 619-1343

AUDIT SHOWS DRAMATIC DECLINE IN MEDICARE OVERPAYMENTS

The U.S. Department of Health and Human Services today reported that improper Medicare payments to hospitals, doctors and other health care providers declined dramatically last year to the lowest error rate since the government initiated comprehensive audits three years ago. The findings are included in an audit report prepared by the Department's Office of Inspector General.

The error rate for fiscal year 1998 was an estimated 7.1 percent, representing estimated improper payments of \$12.6 billion. This compares with an error rate of 11 percent in FY 1997, representing an estimated \$20.3 billion; and 14 percent in FY 1996, representing an estimated \$23.2 billion in improper payments.

"Today's report by the Inspector General is welcome proof that our zero tolerance policy against waste, fraud and abuse is paying off," Secretary Shalala said. "We still have a big job to do in eliminating improper Medicare payments, but with a 45 percent reduction in improper payments in just two years, we are making real progress."

OIG auditors with the support of medical experts reviewed a comprehensive statistically valid sample of Medicare fee-for-service claim expenditures and supporting medical records to determine the accuracy and legitimacy of the claims. They looked at a statistical selection of 600 beneficiaries nationwide with 5,540 claims valued at \$5.6 million and determined that 915 of the claims did not comply with Medicare laws and regulations.

By projecting the sample results over the universe of Medicare fee-for-service benefit payments, which totaled \$176.1 billion during the fiscal year, the OIG calculated that \$12.6 billion was the mid point in the estimated range of improper payments.

HHS Inspector General June Gibbs Brown called the 45-percent reduction in overpayments since FY 1996 "a truly remarkable improvement," and said she was "encouraged by the determined and concerted effort of the Secretary, the Health Care Financing

- MORE -

Administration, the Department of Justice, the Congress and the provider community to effectively address the overpayment problem. This clearly demonstrates what can be accomplished when we work cooperatively to solve such significant problems."

She noted that the improper payments, as with past years, could range from inadvertent mistakes to outright fraud and abuse; the portion of the error rate attributable to fraud could not be quantified.

The two major problem areas were identified as billing for services that were not medically necessary and upcoding services to secure a higher reimbursement than justified. They combined to account for about \$9.3 billion of the estimated \$12.6 billion in improper payments. Another \$2.1 billion in overpayments was attributed to documentation discrepancies, and the remaining \$1.2 billion to billing for services not covered by Medicare, and other types of errors.

Hospitals, physicians and home health agencies accounted for more than 77 percent of the improper payments, with approximately 39 percent of the erroneous claims attributable to hospitals, nearly 26 percent to physicians, and almost 13 percent to home health agencies. Skilled nursing facilities, non-prospective payment system (PPS) hospitals, laboratories, end stage renal disease centers, ambulance companies, ambulatory surgical centers, durable medical equipment suppliers and hospices were responsible for the balance of the improper payments, in that order. Virtually all major provider groups had significant error reductions from FY 1996.

The overwhelming majority of these improper payments (90 percent) were detected through medical reviews coordinated by the Inspector General. When these claims were submitted for payment to Medicare contractors, they contained no visible errors.

Examples of improper payments include a community mental health center that was paid \$21,421 for services later determined by medical reviewers to be medically unnecessary. In another case, a skilled nursing facility billed Medicare \$10,428 for a 51-day skilled-nursing stay by an elderly patient. Because medical records showed that the patient received only maintenance-level, nonskilled care, the payment was denied. In a third case, a physician billed Medicare \$871 for 40 hospital visits. The medical records, however, supported only 18 visits. In each of these instances, and in all other cases where improper payments were specifically identified, action was taken to deny the claim and to recover the overpayment.

Inspector General Brown attributed the reduction in improper payments to several factors including improved program oversight and enforcement and greater compliance by health care providers with Medicare's billing rules. She credited the HCFA for requiring more extensive prepayment reviews of types of claims identified as vulnerable to improper payments, and the provider community for working aggressively with the HCFA to better ensure that they understand and abide by the reimbursement rules.

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"We are very pleased with this evidence of our substantial progress over the last year, even as we continue to accelerate our efforts against waste, fraud and abuse," said HCFA Administrator Nancy-Ann deParle. "I want to thank the Inspector General and our partners at the Department of Justice, as well as members of Congress who have helped give us the enforcement tools and financial resources necessary to turn the tide of waste and fraud in Medicare."

Medicare, the Federal health care program that pays doctor, hospital and other medical bills for the nation's elderly and disabled, served 39 million beneficiaries in FY 1998 and incurred about \$210 billion in benefit payments, including about \$33 billion in managed care expenditures. More than 860 million claims were processed during the fiscal year by the private insurance companies that contract with the government to pay Medicare claims.

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Q&As--FY 1998 Medicare Fee-for-Service Error Rate

1. What was the objective of this audit?

A. Our audit objective was to make an independent assessment of the extent of improper payments in the Medicare fee-for-service program. Specifically, we determined whether services were:

- furnished by certified Medicare providers to eligible beneficiaries;
- reimbursed by Medicare contractors in accordance with Medicare laws and regulations; and
- medically necessary, accurately coded, and sufficiently documented in the beneficiaries' medical records.

2. Has the error rate dropped over the years?

A. Based on our statistical sample, the point estimate of improper Medicare benefit payments made during FY 1998 was \$12.6 billion, or about 7.1 percent of the \$176.1 billion in processed fee-for-service payments reported by HCFA. The estimated range of the improper payments at the 95 percent confidence level is \$7.8 billion to \$17.4 billion, or about 4.4 percent to 9.9 percent, respectively. This year's point estimate is \$7.7 billion less than last year's point estimate of \$20.3 billion and \$10.6 billion less than the previous year's point estimate of \$23.2 billion.

3. How were these improper payments determined?

A. Through detailed medical and audit reviews of a statistical selection of 600 beneficiaries nationwide with 5,540 fee-for-service claims processed for payment during FY 1998, we found that 915 claims did not comply with Medicare laws and regulations. Medical review personnel from HCFA's Medicare contractors and peer review organizations (PRO) assessed the medical records to determine whether the services billed were reasonable, medically necessary, adequately documented, and coded in accordance with Medicare reimbursement rules and regulations.

4. You say in your report that you cannot quantify what portion of the error rate is attributable to fraud. What are these errors, and was fraud noted in your sample?

A. The improper payments identified by our review could range from inadvertent mistakes to outright fraud and abuse. We did, in fact, refer certain cases to our Office of Investigations for further development.

However, we did not routinely profile individual providers to the degree needed to

develop a fraud case to prove intent or reckless disregard for Medicare rules and regulations. This would have been beyond the scope of our audit.

5. Based on your audit, what factors do you believe contributed to the decline in this year's error rate?

A. We attribute the decline in the error rate to several factors:

- HCFA's efforts under the Medicare Integrity Program,
- Fraud and abuse initiatives,
- Improved provider compliance with Medicare reimbursement rules,
- HCFA/OIG outreach efforts emphasizing provider compliance with Medicare documentation requirements, and
- Implementation of HCFA's corrective action plan.

6. In your opinion, what fraud and abuse initiatives helped reduce the error rate?

A. Fraud and abuse initiatives on the part of the Administration and the Congress have had a significant impact. For example, Operation Restore Trust placed greater emphasis on more in-depth reviews of HHA claims. Also, the Health Insurance Portability and Accountability Act has provided both HCFA and OIG with a stable funding source for Medicare program payment safeguards, as well as fraud and abuse activities, for the next several years.

The Health Care Fraud and Abuse Control Program, under the joint direction of the Attorney General and the Secretary (acting through OIG), established a nationwide effort to coordinate Federal, State, and local law enforcement activities with respect to health care fraud. Also, the OIG, in consultation with HCFA, the Department of Justice, and the provider community, has developed guidance for specific health care industry sectors on how they may improve adherence to Medicare rules by establishing voluntary, comprehensive compliance programs. The adoption of such programs works to prevent fraud, waste, and abuse in the health care industry; helps efforts to provide quality care to patients; and assists health care entities in developing effective internal controls that reduce or eliminate submission of false or inaccurate claims.

7. What types of improper payments did you find?

A. Over the past 3 years we have identified improper payments by these major categories of errors: (1) documentation errors, (2) lack of medical necessity, (3) incorrect coding, and (4) noncovered/unallowable services.

Documentation for FY 1998 included two components: (1) insufficient documentation to determine the patient's overall condition, diagnosis, and extent of services performed and (2) no documentation to support the services provided.

Lack of medical necessity covers situations where the medical records contained sufficient documentation to allow the medical review staff to make an informed decision that the medical services or products received were not medically necessary.

Incorrect coding covers situations where the contractor medical review staff determined that the documentation submitted by providers supported a lower reimbursement code. We also identified a few instances of downcoding which were offset against identified upcoding situations.

Unallowable services are defined as those that Medicare will not reimburse because the services do not meet Medicare reimbursement rules and regulations.

8. As far as the medical records, exactly what is "sufficient documentation"?

- A. Medicare regulations, 42 CFR 482.24(c), specifically require providers to maintain medical records that contain sufficient documentation to justify diagnoses, admissions, treatments performed, and continued care. This documentation includes all providers' orders, nursing notes, reports of treatment, medication records, radiology, laboratory reports, vital signs, and other information necessary to monitor the patient's condition.

The medical record must be accurately written, promptly completed, properly filed and retained, and accessible. Medical records must be retained for a period of at least 5 years.

Let me give you an example of insufficient documentation. Medicare paid a physician \$871 for 40 hospital visits. The medical records, however, supported only 18 visits. Therefore, payment of \$479 for the 22 visits without supporting documentation was denied.

9. In the category of documentation errors, aren't these problems really more a matter of form rather than substance?

- A. Medicare, like other insurers, makes payments based on a standard claim form. Medicare regulation, 42 CFR 482.24(c), specifically requires providers to maintain records that contain sufficient documentation to justify diagnoses, admissions, treatments performed, and continued care. If providers failed to provide documentation or submitted insufficient documentation, the contractors or OIG staff generally requested supporting medical records at least three times before determining the payment to be improper. Thus, for these errors, the medical review staff could not determine whether services billed were actually provided to the Medicare beneficiaries or the extent of services performed. It should be noted that HCFA subsequently upheld almost 99 percent of all overpayments identified in our past samples and recovered approximately 94 percent.

10. Your report notes that of the four principal error categories, the reduction in documentation errors is most dramatic. Can you explain why?

A. This year, we found an \$8.7 billion drop in documentation errors since FY 1996. We believe that substantial improvement was achieved primarily because of:

- HCFA and OIG outreach efforts. With the release of our FY 1996 report, OIG and HCFA together briefed providers on the audit results and Medicare documentation requirements.
- Implementation of HCFA's corrective action plan. Since the OIG released its FY 1996 audit results, HCFA asked its contractors to perform prepayment reviews on selected claims for evaluation and management codes. Contractors were also asked to increase their overall level of claims review (pre-pay and post-pay), including the review of supporting documentation.

Even with the notable reduction in documentation errors this year, we estimate that these errors total \$2.1 billion. Continued efforts are therefore needed to reinforce to providers the need to maintain medical records supporting their claims.

11. Your report mentions that errors due to lack of medical necessity represent the highest error category in FY 1998. Can you further explain this error category?

A. This error category covers situations where the medical records contained sufficient documentation to allow the medical review staff to make an informed decision that the medical services or products received were not medically necessary. As in past years, the Medicare contractor or PRO medical staff made decisions on medical necessity using Medicare reimbursement rules and regulations. They followed their normal claim review procedures to determine whether the medical records supported the Medicare claims.

For example, a SNF was paid \$10,428 for a 51-day skilled nursing stay. However, the patient's medical records documented that the patient received only maintenance-level (nonskilled) nursing home care, such as routine occupational therapy and the continuation of routine medication. Because Medicare does not reimburse for nonskilled services, the entire payment was denied.

12. Would you please describe how you requested appropriate medical records from the providers?

A. We asked the Medicare contractors to send a letter to each provider in our sample to obtain copies of all medical records supporting services billed.

We specifically requested that they provide us with applicable office/hospital/medical records for each identified beneficiary for all services they provided for the specified date. We requested that copies of pertinent documents be sent to a specified OIG contact on the premises of the contractor within 30 days of the date of the letter.

In the event that a response was not received, a second letter was sent. If the providers still did not provide adequate documentation after the second formal contact, we made repeated attempts by letter, phone, and, in some cases, onsite visits.

- 13. The report says Medicare is still overpaying by billions of dollars and that Medicare is still at high risk for payment errors. Do you think additional corrective actions are needed to curtail this misspending?**

A. The HCFA has made substantial progress in reducing improper payments in the Medicare program. However, continued efforts are needed to reduce the current estimate of over \$9 billion in errors due to the lack of medical necessity and incorrect coding. Our recommendations address the need for HCFA to continue its diligence in reducing past identified problems and to keep abreast of those issues that could negatively affect future error rates.

- 14. You report that 90 percent of improper payments were detected through medical review. Could these types of errors be detected before claim processing?**

A. The improper payments in our sample were detected through medical record reviews coordinated by the OIG in conjunction with medical personnel. When these claims were submitted for payment, they contained no visible errors. The Medicare contractors' claim processing systems were generally adequate for ensuring beneficiary and provider eligibility, pricing the claims based on information submitted, and ensuring the services billed were allowable under Medicare rules and regulations. However, since the OIG released its FY 1996 audit results, HCFA developed and initiated several corrective actions designed to reduce Medicare payment errors. For example, in FY 1998, HCFA asked its contractors to perform prepayment reviews on selected claims for evaluation and management codes. In addition, HCFA asked contractors to increase their overall level of claims review (pre-pay and post-pay), including the review of supporting documentation.

THE WHITE HOUSE
WASHINGTON

401
5703

FAX COVER SHEET

TO: Nancy ANN

FROM: Jeanne + Chris

ATTACHED ARE:

- (1) Summary of Medicare + Medicaid
SAVINGS, with "#" INDICATING
THAT THE Policy WAS Recommended
BY OIG
- (2) THE OIG REFERENCE (COULDN'T FIND
THE EPO. REPORT)

ALTOGETHER, \$675m in 2000

\$5.4 billion / 5 years -

Came From OIG - Recommended
Program Integrity

PRESIDENT'S CLINTON'S FY 2000 BUDGET:
IMPROVING THE EFFICIENCY AND INTEGRITY OF MEDICARE AND MEDICAID
February 1, 1999

The President's FY 2000 budget proposes a series of Medicare and Medicaid policies to continue the ongoing effort to put these critical programs on sound financial footing to better prepare for the challenges of the next century. Since taking office, the President has proposed and implemented many policies to reduce overpayment and combat fraud and abuse in Medicare and Medicaid. This no-tolerance approach has yielded billions of dollars in savings, and has contributed to very low growth rates in the past several years. This budget proposes additional efforts to strengthen our commitment to eliminate fraud, waste and abuse in the Medicare program and ensure that payments to hospitals and other providers are reasonable. Together, they will save an estimated \$1.3 billion in the year 2000 and \$10.9 billion over 5 years.

MEDICARE

The President's budget contains a series of policies to reduce overpayments and waste, fraud, and abuse in Medicare. These policies are grounded in studies and research that indicates that they are not only reasonable but necessary to assure Medicare's fiscal integrity. Together, they save an estimated \$1.265 billion in FY 2000, \$9.55 billion over 5 years (including Part B premium offset and Medicaid effects).

- ① • **Eliminating overpayments for epogen.** This proposal reduces Medicare reimbursement for Epogen (a drug used to treat anemia) to reflect current market prices. The HHS Office of the Inspector General (OIG) found in a 1997 study that the current Federal reimbursement rate for Epogen exceeded the market price of the drug by \$1 per 1,000 units. (Savings: \$70 million in FY 2000; \$450 million over 5 years).
- ② • **Ensuring that Medicare does not pay for claims owed by private insurers.** This proposal would take steps to ensure that Medicare does not pay for claims owed by private insurers, including requiring private insurers to report any Medicare beneficiaries they cover, allowing Medicare to recoup double the amount owed by insurers who purposely let Medicare pay claims the group plan should have made, and imposing fines for failing to report no-fault or liability settlements for which Medicare should have been reimbursed. Too often, Medicare pays claims that are owed by private insurers because it has no way to verify that the beneficiary has other insurance that should pay those claims. (Savings: \$10 million in FY 2000; \$640 million over 5 years).
- ③ • **Eliminating excessive Medicare reimbursement for drugs.** This proposal would eliminate the mark-up for drugs by basing the Medicare reimbursement on the provider's actual acquisition cost of the drug. A recent report by the OIG found that Medicare currently pays hundreds of millions of dollars more for 22 of the most common and costly drugs than would be paid if market prices were used. (Savings: \$140 million in FY 2000; \$950 million over 5 years).

- ④ • **Eliminating abuse of Medicare's partial hospitalization benefit.** This proposal would preclude providers from furnishing partial hospitalization services in a beneficiary's home or in an inpatient or nursing home. It would also authorize the Secretary of Health and Human Services to set additional criteria for partial hospitalization services furnished by community mental health centers. Currently, many providers bill Medicare for partial hospitalization services that do not meet the reimbursement criteria. (Savings \$20 million in FY 2000 and \$205 million over 5 years).
- **Using a competitive pricing process for certain routine surgical procedures.** This proposal would expand HCFA's current "Centers of Excellence" demonstration to allow Medicare to receive volume discounts on certain routine surgical procedures. In a smaller scale demonstration that HCFA conducted in the early 1990's, evaluators found that HCFA was able to reduce its costs by approximately 12 percent per procedure while improving clinical outcomes. (Savings: \$0 in FY 2000 (effective in FY 2001); \$690 million over 5 years).
- **Establish a national limit for all prosthetics and orthotics.** This proposal would establish national payment limits, based upon the median state fee schedule, for prosthetics and orthotics. Currently, some prosthetics and orthotics are paid on the basis of regional fee schedules that are subject to floors and ceilings, which is inconsistent with how other prosthetics and orthotics and durable medical equipment is paid. (Savings: \$70 million in FY 2000; \$580 million over 5 years).
- ⑤ • **Reducing the Medicare lab test fee reimbursement ceiling.** This proposal would lower the cap on lab payment amounts from 74 percent of the median of all fee schedules to 72 percent of the median. HCFA has found that it overpays for numerous lab compared to the private sector. This policy corrects for this overpayment nationwide (Savings: \$70 million in FY 2000; \$550 million over 5 years).
- **Reducing the hospital market basket.** This proposal would reduce the FY 2000 inpatient PPS update by 0.9 percent below the current level provided by the BBA. Recent data from the Medicare Payment Advisory Commission and other independent sources confirm that hospitals will have record-high margins in FY 1999 and maintain these high levels through at least 2002. Hospitals are projected to earn 16 percent Medicare margins over this time period. This policy would bring Medicare payments more in line with the current cost structure of the hospital industry. (Savings: \$650 million in FY 2000; \$3.880 billion over 5 years).
- ⑥ • **Reducing Medicare bad debt payments.** This proposal would reduce Medicare bad debt payments to hospitals from 45 percent to 55 percent and extend the reductions to other providers. The Congressional Budget Office and the OIG argue that Medicare's policy to pay for bad debts creates incentives for providers not to collect their unpaid deductibles and copayments. The Balanced Budget Act took a step towards removing these incentives, but did not apply the reductions to all providers or reduce payments as much as recommended. (Savings: \$360 million in FY 2000; \$2.47 billion over 5 years).

MEDICAID

The President's budget would address two issues in Medicaid that have led to overpayments to states and providers: administrative cost allocation and rebates for generic drugs. Together, they save an estimated \$74 million in FY 2000, \$1.405 billion over 5 years (including interactions with Medicare policy changes).

- **Medicaid cost allocation.** As an unintended consequence of welfare reform, states' Medicaid administrative expenditures have increased because of changes in how administrative costs are shared by TANF and Medicaid. Last year, Congress addressed this issue for Food Stamps. This proposal would extend the same approach to Medicaid. Rather than a flat reduction in the Medicaid matching rate, it would determine liabilities on a state-by-state basis. It would also allow states to use TANF block grant funds to cover shared TANF-Medicaid costs. (Savings: \$59 million in FY 2000; \$1.2 billion over 5 years).
- **Medicaid rebates from generic drug manufacturers.** This proposal would revise the Medicaid drug rebate law to require additional rebates from generic manufacturers when they increase the price of drugs in excess of the CPI-U. Under current law, generic manufacturers are exempt from the additional Medicaid rebates imposed on brand name manufacturers. This proposal would treat generic drug manufacturers more like brand name drug manufacturers. (Savings: \$5 million in FY 2000; \$125 million over 5 years).

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IMPROVE MEDICARE SECONDARY PAYER SAFEGUARDS

Current Law:

Medicare is the secondary payer (MSP) to certain group health plans in instances where medical services were rendered to Medicare-entitled employees or to the Medicare-entitled spouses and other family members of employees. Medicare is also the secondary payer in situations involving coverage under Worker's Compensation; black lung benefits; automobile and nonautomobile, no fault, or liability insurance; and Department of Veterans Affairs programs. The HCFA provides administrative funds to Medicare contractors to monitor and collect incorrect primary benefits paid on behalf of Medicare beneficiaries.

Proposal:

The HCFA should (1) ensure that contractor resources are sufficient and instruct contractors to recover improper primary payments from insurance companies other than the Blue Cross and Blue Shield insurance companies, (2) implement financial management systems to ensure all overpayments (receivables) are accurately recorded, (3) develop detailed procedures to properly handle employers that refuse to provide other health insurance coverage information, and (4) resubmit the justification of a legislative proposal that would require insurance companies, underwriters, and third-party administrators to periodically submit private insurance coverage data directly to HCFA.

Legislative



Regulatory



Other Administrative



Reason for Action:

Although agreement was reached to relieve all Blue Cross and Blue Shield plans of past due MSP overpayments and although there is a 3-year future plan to identify MSP situations, it applies only to the Blue Cross and Blue Shield plans and not to other insurance companies. Additional measures are still needed to collect accurate and timely information on other primary payers. This will help to reduce future Medicare overpayments that result from unidentified MSP cases and improve the recovery process for overpayments.

Savings (in millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
TBD	TBD	TBD	TBD	TBD

Status:

The HCFA is pursuing the recommended administrative actions through improved processes to identify and recover overpayments related to MSP, as well as improved information systems to guard against making improper Medicare payments where the Blue Cross and Blue Shield plans are primary payers. However, safeguards are still needed to guard against improper payments where insurance companies other than the Blues are primary payers.

Report:

A-09-89-00100 (Final management advisory report, Mar. 1990)
OEI-07-90-00760 (Final report, Aug. 1991)
OEI-03-90-00763 (Management advisory report, Nov. 1991)
A-09-91-00103 (Final report, Aug. 1992)
A-14-94-00391 (Final report, Dec. 1993)
A-14-94-00392 (Final report, Mar. 1994)

REVISE MEDICARE PRESCRIPTION DRUG PAYMENT METHODS

Current Law:

Medicare Part B covers prescription drugs for certain medical disorders, such as end stage renal disease and cancer, and when necessary for the effective use of durable medical equipment. Reimbursement is based on the lower of an estimated acquisition cost or a national average wholesale price (AWP). Payment for drugs under the Medicaid program varies among the States but generally includes use of a discounted acquisition cost, as well as a federally mandated manufacturers' rebate program.

Proposal:

The HCFA should reexamine its Medicare drug reimbursement methodologies with a goal of further reducing payments as appropriate.

Legislative



Regulatory



Other Administrative



Reason for Action:

Several OIG studies have indicated that Medicare pays more than other payers for prescription drugs. For example, for three nebulizer drugs in 1994, Medicare and its recipients could have saved substantial amounts by using a discounted AWP reimbursement formula similar to that used by many Medicaid States. Another review of 17 high-volume prescription drugs in the Medicare program in 1994 showed the possibility of substantial savings based on a manufacturer rebate similar to that obtained by the Medicaid program. A more recent review found that manufacturers' published AWP considerably overstates the actual wholesale cost. For 22 drugs with high Medicare allowance amounts, Medicare could have saved \$447 million in 1996 by using actual wholesale prices rather than the manufacturers' published AWP. Savings for all Medicare drugs could have been as much as \$667 million in 1996.

Savings (in millions):

The savings will depend on the percentage by which the AWP is discounted for Medicare payments. The Balanced Budget Act of 1997 reduced Medicare payments to 95 percent of the AWP. The following estimates, based on a Congressional Budget Office estimate of those savings, show the effects of additional 5 and 10 percent reductions.

	<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
90% of AWP	\$ 80	\$110	\$110	\$40	\$30
85% of AWP	160	220	220	80	60

Status:

The HCFA concurred with our recommendation. As noted above, the Balanced Budget Act of 1997 limited Medicare payments for drugs to 95 percent of the AWP.

Report:

OEI-03-94-00390 (Final report, Mar. 1996)
 OEI-03-95-00420 (Final report, May 1996)
 OEI-03-97-00290 (Final report, July 1997)

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LIMIT PROSPECTIVE PAYMENT SYSTEM REIMBURSEMENT FOR HOSPITAL ADMISSIONS NOT REQUIRING AN OVERNIGHT STAY

Current Law:

Under the prospective payment system (PPS), hospitals are reimbursed for each admission when the patient is discharged based on established rates which are grouped into diagnosis related groups (DRG). Current Medicare instructions provide that an admission occurs when it is expected that the patient will occupy a bed and remain overnight. This applies even if the person is later discharged or transferred to another hospital without actually using a hospital bed overnight.

Proposal:

The HCFA should seek legislation to pay for covered services related to 1-day admissions without an overnight stay as outpatient services which are paid on the basis of the lower of the actual costs or the customary charges in a locality.

Legislative

☒

Regulatory

☐

Other Administrative

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Reason for Action:

Based on Medicare records for 1989, our follow-up review (A-05-92-00006) revealed that the volume of 1-day admissions on a national basis had increased approximately 150 percent over 1985 levels and that Medicare had paid for 179,500 admissions that did not require overnight stays. Many of these cases related to observations after emergency or outpatient services, to surgeries later canceled, or to acute care stays of doubtful necessity. In many cases, documentation revealed that few, if any, services were provided while the patient was an inpatient.

Savings (in millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
\$210	\$210	\$210	\$210	\$210

Status:

The HCFA proposed to implement our recommendation through administrative remedies which would designate whether specific services are to be covered and paid for as inpatient or outpatient services. No proposal was included in the President's current budget.

Report:

A-05-89-00055 (Final report, July 1989)
A-05-92-00006 (Final report, Jan. 1992)

CHANGE THE WAY MEDICARE PAYS FOR CLINICAL LABORATORY TESTS

Current Law:

The amount the Medicare program pays for most clinical lab tests is based on fee schedules. These fee schedules, effective July 1, 1984, were established by each carrier at 60 percent of the Medicare prevailing rate (the rate most frequently used by all suppliers). The Congress took action in the Omnibus Budget Reconciliation Act of 1990 to pay comparable prices by limiting the annual fee schedule increase to 2 percent for 1991, 1992, and 1993 and by reducing the national cap to 88 percent of the median of all fee schedules. The Omnibus Budget Reconciliation Act of 1993 further reduced the national Medicare fee cap to 80 percent of the median of carrier prices in 1995 and to 76 percent in 1996. The law also called for no cost-of-living increases for 1994 and 1995.

Proposal:

The HCFA should (1) develop a methodology and legislative proposal to pay for tests ordered as custom panels at substantially less than the full price for individual tests and (2) study reinstating the beneficiary coinsurance and deductible provisions for laboratory services as a means of controlling utilization.

Legislative



Regulatory



Other Administrative



Reason for Action:

The Omnibus Budget Reconciliation Act of 1993, if fully implemented, should reduce the higher profit rates from Medicare billings. However, although prices on individual tests are being reduced by legislation, panels are still generally being billed as individual tests to Medicare. Medicare policies are not sufficient to control the billing of profile tests because there is no requirement that the tests ordered as a panel by the physician be billed only as a panel. The HCFA's guidelines do not address the problem of panels as a marketing mechanism of the laboratory industry or the problem of industry billing for the contents of the panels individually. In our opinion, these conditions have contributed to the significant increase in the use of laboratory services.

Savings (in millions):

	<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
Panels	TBD	TBD	TBD	TBD	TBD
Co-payment	\$1,130	\$1,240	\$1,370	\$1,520	\$1,690

Status:

The HCFA concurred with our first recommendation but not our second. The agency recently added that it is encouraging the individual ordering of tests to help control utilization and is therefore discouraging the creation of laboratory or physician specific customized panels.

The Balanced Budget Act of 1997 reduces Medicare fee schedule payments by lowering the cap to 74 percent of the median for payment amounts beginning in 1998. Also, there will be no inflation update between 1998 and 2002.

Report:

A-09-89-00031 (Final report, Jan. 1990)
A-09-93-00056 (Follow-up report, Jan. 1996)

MODIFY PAYMENT POLICY FOR MEDICARE BAD DEBTS

Current Law:

Under Medicare's prospective payment system (PPS), hospitals are reimbursed for inpatient services rendered to Medicare beneficiaries by a fixed payment amount based on a diagnosis related group (DRG). However, bad debts related to unpaid deductible and coinsurance amounts are reimbursed separately as pass-through (i.e., reimbursed outside of DRG) items under reasonable cost principles.

Proposal:

We presented an analysis of four options for HCFA to consider, including the elimination of a separate payment for bad debts, the offset of Medicare bad debts against beneficiary Social Security payments, the limitation of bad debt payments to prospective payment system hospitals which are profitable, and the inclusion of a bad debt factor in the DRG rates. The HCFA should seek legislative authority to further modify bad debt policies.

Legislative



Regulatory



Other Administrative



Reason for Action:

Our review of HCFA's Hospital Cost Report Information System showed that total Medicare bad debts increased from \$159 million during the second year of PPS (FY 1985) to \$398 million during the fifth year of PPS (FY 1988). During this same period, hospitals continued to earn significant profits. Also, hospital bad debt collection efforts have often been less than adequate since there is little incentive for a hospital to collect the unpaid deductible and coinsurance amounts when Medicare pays these amounts.

Savings (in millions):

<u>FY 1</u>	<u>FY 2</u>	<u>FY 3</u>	<u>FY 4</u>	<u>FY 5</u>
TBD	TBD	TBD	TBD	TBD

Status:

Agreeing with our recommendation to include a bad debt factor in the DRG rates, HCFA said that our report should assist the Congress in understanding the rapid growth in hospital bad debts. The Balanced Budget Act of 1997 provides for some reduction of bad debt payments to providers, but additional legislative changes are needed to implement the modifications we recommended.

Report:

A-14-90-00339 (Final report, June 1990)

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**THE IMPACT OF HIGH-PRICED
GENERIC DRUGS
ON MEDICARE AND MEDICAID**



**JUNE GIBBS BROWN
Inspector General**

**JULY 1998
OEI-03-97-00510**

EXECUTIVE SUMMARY

PURPOSE

To determine the impact of high-priced generic drugs on the Medicare and Medicaid programs.

BACKGROUND

Both Medicaid and Medicare pay billions of dollars each year for prescription drugs. The Medicaid program paid nearly \$10 billion for prescription drugs in 1995. Although Medicare provides reimbursement for only certain types of drugs, the Part B program still paid more than \$2.3 billion dollars for prescription drugs in 1996.

On January 1, 1998, Medicare Part B began to reimburse covered drugs at 95 percent of the average wholesale price (AWP). This change in reimbursement was the result of legislation enacted by Congress. Previously, Medicare carriers determined the amounts that Medicare paid for prescription drugs based on the lower of the Estimated Acquisition Cost (EAC) or the national (AWP). Historically, carriers had used 100 percent of AWP and not estimated acquisition cost to determine Medicare reimbursement allowances for prescription drugs.

For drugs with generic versions, Medicare carriers determine reimbursement based on 95 percent of the median AWP for all generic versions of the drug. Prior to January 1998, Medicare reimbursed drugs with generic versions at 100 percent of the median AWP. Medicare reimbursement amounts include both the amount that Medicare and its beneficiaries pay a drug supplier.

In general, State Medicaid agencies use either a discounted AWP or estimated/wholesale acquisition cost method to reimburse prescription drugs. State Medicaid agencies also receive manufacturer drug rebates.

This inspection report resulted from a Congressional request concerning high-priced generic drugs. Using the drugs identified in the request, we collected data from three main sources. To verify NDC codes and average wholesale prices, we reviewed data from the July 1997 *Red Book* CD-ROM update. We compiled Medicare statistics from the National Claims History (NCH) File. We collected drug rebate data from the Medicaid Drug Rebate Initiative (MDRI) System.

FINDINGS

Medicare and its beneficiaries could have saved \$5 million to \$12 million for four drugs if 1997 reimbursement had not been based on higher-priced generic versions.

We found several cases where average wholesale prices for generic products were three to four times greater than the brand price. For the four drugs reviewed, we determined that the Medicare program and its beneficiaries could have saved \$5 million dollars if 1997 reimbursement had been based on the average wholesale price of the brand-name products. If reimbursement had been

based on the median of generic drugs with prices less than the brands, Medicare and its beneficiaries could have saved \$12 million for the four drugs.

Florida's Medicaid program could have saved half a million dollars for just eight drugs in 1996 if higher-priced generic drugs had been reimbursed at brand prices.

Using the current reimbursement formula, Florida Medicaid in some cases paid three times more for a generic than it did for the brand version of the eight drugs reviewed. After factoring in manufacturer rebates, the program paid more than five to eight times more for generics than brand products. If Florida Medicaid had capped reimbursement for higher-priced generic drugs at the reimbursement level for the highest-priced brand drug, nearly half a million dollars would have been saved for just eight drugs in 1996.

RECOMMENDATIONS

There is evidence that high-priced generic drugs have a significant financial impact on Medicare and Medicaid reimbursement. We found that the inclusion of higher-priced generic drugs in Medicare payment calculations can raise allowances above the price of brand-name drugs. In the Medicaid program, utilization of higher-priced generic drugs was widespread among the drugs reviewed.

We believe further reductions need to be made in Medicare and Medicaid reimbursement for prescription drugs. We continue to support the Health Care Financing Administration's legislative proposal to link Medicare reimbursement to the acquisition cost of prescription drugs. However, until broader legislation is enacted, we believe refinements to the current system are needed. Since the changes recently enacted by Congress continue to link reimbursement to average wholesale prices, we believe that mechanisms should be in place to limit the impact that high-priced generic drugs have on reimbursement. Medicare's new reimbursement methodology for prescription drugs will not prevent higher-priced generics from increasing Medicare allowances. Higher-priced generic drugs will still be included in the median calculation. When the median generic policy was implemented, generic prices were normally less than those of the brand-name product. However, what may have originally been a cost-saving mechanism has, for certain categories of drugs, become a losing proposition. 

We believe that the Medicare program should take action to prevent these situations. We recommend that the Health Care Financing Administration 1) not include higher-priced generic drugs in the median calculation to determine Medicare allowances, or 2) propose limiting Medicare allowances to brand prices when higher-priced generic drugs are involved.

In contrast to the Medicare program which pays for brand and generic drugs at the same rate, Medicaid reimburses based on the specific drug supplied. Therefore, we recommend that the Health Care Financing Administration limit Medicaid reimbursement of higher-priced generic drugs to the amount reimbursed (prior to rebate) for lower-priced brand or appropriately-priced generic drugs.

Date: _____

FAX

▼ Health Division 林
Office of Management and Budget
Executive Office of the President
Washington, DC 20503

To: DEVORAH

From: YVETTE

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Subject:

Comment:

Voice Numbers:

Health Division (Front Office)

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Health Programs & Services Br

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65557

EXPEDITE
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DATE: 10/29/99

TO: ANN KENDRALL and Yvette Shenouda**ADDRESS:** OMB**PHONE:****FAX NO.:** 202-395-4922

FROM: Gloria Bell
Senior Budget Analyst, Office of Budget, ASMB,
Department of Health and Human Services**ADDRESS:** Room 503-H
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201**PHONE:** (202) 690-6283**FAX NO.:** (202) 690-6896

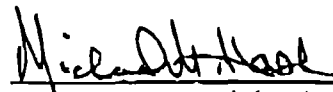
PAGE 1 of: 4**SUBJECT:** Medicare Integrity Program

MESSAGE: Please review and provide comments/clearance by COB Monday, November 1,
1999. Thanks**EXPEDITE**

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

Medicare Integrity Program



Michael M. Hash
Deputy Administrator, HCFA

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.

Date: _____

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Medicare Integrity Program



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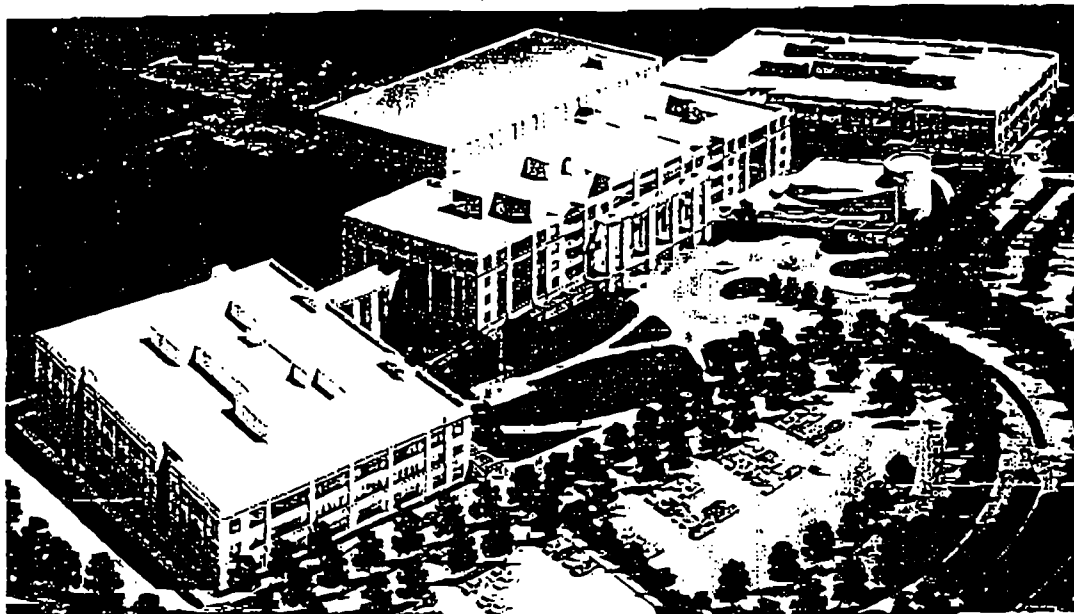
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HEALTH CARE FINANCING ADMINISTRATION
NATIONAL HEADQUARTERS
7500 Security Boulevard
Baltimore, MD 21244-1850



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REMARKS:

Just got the report - it turns out that it came out of the office of special investigations @ GAO, which usually does not share stuff w/us before release (cuz it's part of a criminal investigation). As you will see, the report is actually a look behind of 7 investigations that took place between 1992 & 1997.

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Washington, DC 20548

Office of Special Investigations

B-283695

October 5, 1999

The Honorable Susan M. Collins
Chairman
Permanent Subcommittee on
Investigations
Committee on Governmental Affairs
United States Senate

Subject: Health Care Fraud Schemes Committed by Career Criminals and Organized
Criminal Groups and Impact on Consumers and Legitimate Health Care
Providers

Dear Madam Chairman:

This report responds to your July 27, 1998, request that we provide you with information concerning the nature and magnitude of illegal activity by career criminal and organized criminal groups posing as health care providers for the purpose of defrauding federal, state, and private insurance systems. Both Medicare and Medicaid programs, because of their size and complexity, are vulnerable to fraud and abuse. We have reported previously about the importance of controlling health care costs, especially in the federal government.¹ Controlling fraud is part of the remedy for controlling health care costs. In fiscal year 1998, the latest year for which statistics are available, Medicare paid out more than \$193 billion and Medicaid spent approximately \$177 billion.

The Coalition Against Insurance Fraud, using private insurance information provided by the Health Insurance Association of America and public insurance information supplied by the Health Care Financing Administration (HCFA), estimated the dollar amount of nationwide health care claim fraud for 1997² to be \$58.9 billion. Of this amount, approximately

¹ Medicare: HCFA's Use of Anti-Fraud and Abuse Funding and Authorities (GAO/HEHS-98-160, June 1, 1998); Private Health Insurance: Continued Erosion of Coverage Linked to Cost Pressures (GAO/HEHS-97-122, July 24, 1997); Medicaid Fraud and Abuse: Stronger Action Needed to Remove Excluded Providers From Federal Health Programs (GAO/HEHS-97-63, Mar. 31, 1997); High Risk Series: Medicare (GAO/HR-97-10, Feb. 1997).

² The most current year for which statistics were available was 1997.

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without the
approval of the Office of Congressional Relations.

B-283695

\$20 billion was attributed to fraudulent private insurance claims; and approximately \$34 billion was attributed to fraudulent public insurance claims, including Medicare and Medicaid.³ There is a growing trend in health care fraud in which sham providers are entering the health care system with the sole and explicit purpose of exploiting it. Rather than first providing services at an inflated cost, these criminals often bill Medicare while providing no or inferior services. As our review determined, however, this trend is not limited to the Medicare program. State Medicaid programs and private insurers throughout the country are being defrauded in the same manner. Within the past several years, state and federal law enforcement officials in every part of the country have uncovered such fraud.

In order to address the proliferation of health care fraud on the part of criminals and organized criminal groups, you asked us to report on (1) the makeup and prior activities of such groups; (2) how organized criminal groups created medical entities or used legitimate medical entities or individuals to defraud Medicare, Medicaid, and private insurers; (3) schemes used by such groups to commit health care fraud; and (4) the impact that illegal activity by such groups has on consumers and legitimate health care providers.

To develop this information, we identified seven criminal health care fraud investigations for review. In the four cases involving Medicare and Medicaid fraud, the leaders of each criminal group pled guilty to federal or state criminal charges related to health care fraud. These charges included conspiracy to defraud the United States, conspiracy to commit money laundering, mail fraud, racketeering, conspiracy to commit racketeering, and/or organized fraud. In the three private insurance cases, the leaders of each group were indicted: one is awaiting trial while the other two are fugitives. Cases against other group members in each of the seven groups are in various stages of completion, with some members having pled guilty to criminal charges and other members in fugitive status following indictments.

We interviewed federal and state law enforcement officials associated with the investigations we reviewed and largely relied upon their investigative findings in preparing our report. Plea agreements, along with stipulations of fact and/or criminal information contained in court documents, generally confirmed many of the investigative findings. The investigations involved criminal groups that were representing themselves as legitimate providers and, allegedly, billing public and private insurance systems for medical services and equipment not rendered or not necessary. The cases we reviewed involved a combination of Medicare, Medicaid, and private insurance fraud or alleged fraud occurring in Florida, North Carolina, and Illinois between 1992 and 1998, with the period of fraud or alleged fraud in each case lasting between 3 months and 4 years. In the seven cases we reviewed, the fraudulent claims ranged from between \$795,000 to more than \$120 million, of which between \$72,000 and over \$32 million were actually paid by either Medicare,

³ These figures are estimates of claim fraud. They do not include costs related to the detection, investigation, or prosecution of insurance fraud, nor has there been any attempt to estimate the amount of fraud committed by insurers or those purported to be in the business of insurance.

Medicaid, private insurers, or a combination thereof. With respect to the cases involving private insurers, alleged fraudulent claims were filed with between 18 to over 100 insurance companies and self-insured plans. (See encl. I for a more detailed scope and methodology.)

Results in Brief

While the full extent of the problem remains unknown, we did determine that career criminal and organized criminal groups are involved in Medicare, Medicaid, and private insurance health care fraud or alleged fraud throughout the country. In the cases we reviewed, criminal groups varied in size from 2 or 3 participants to more than 20 participants and generally had one leader. Many group members had prior criminal histories for criminal activity unrelated to health care fraud, indicating that they moved from one field of criminal activity to another. The primary subjects in these cases had little or no known medical or health care education, training, or experience. At least two groups learned or were suspected of having learned how to commit health care fraud from others already engaged in such fraud. In some of the cases we reviewed, criminal-group members had relatives or associates in foreign countries who helped them transfer their ill-gotten health care proceeds.

These groups created as many as 160 sham medical entities—such as medical clinics, physician groups, diagnostic laboratories, and durable medical equipment (DME)⁴ companies, often using fictitious names or the names of others on paperwork—or used the names of uninvolved legitimate providers to bill for services and equipment not provided or not medically necessary. For the most part, these entities existed only on paper. Once the structure was in place, subjects used a variety of schemes to submit claims to Medicare, Medicaid, or private insurance companies.

One scheme used is sometimes referred to as "patient brokering" or "rent-a-patient." Under this scheme, which was used in one of the Medicare cases, the subjects used "recruiters" (also known as "runners") to organize and recruit beneficiaries (patients)⁵ who visited clinics owned or operated by such subjects for unnecessary diagnostic testing and/or medical services. Recruiters received a fee for each beneficiary brought in; hence they "rented" or "brokered" the beneficiary and/or identifying information to the subjects. In turn, recruiters paid a portion of their fee to each cooperating beneficiary. The

⁴ Durable medical equipment, or "DME," includes such things as iron lungs, oxygen tanks, oxygen concentrators, hospital beds, and wheelchairs used in the patient's home, whether furnished on a rental basis or purchased; blood-testing strips and blood glucose monitors for individuals with diabetes; and seat-lifting mechanisms.

⁵ "Recruiters" are individuals who are paid by providers to bring beneficiaries to their clinics or offices for unnecessary medical services at no charge to the beneficiaries. Recruiters usually share a portion of their fees with cooperating beneficiaries.

⁶ Medicare-covered patients are most often referred to as "beneficiaries"; Medicaid-covered patients are referred to as "recipients"; and private insurance-covered patients are referred to as "insureds." For the purpose of simplification, we will refer to all insured individuals (patients) as "beneficiaries" in this report.

B-283695

beneficiaries' insurance was later billed for these and other services or equipment not provided. In addition to the beneficiaries, some physicians were willing to collaborate with subjects in exchange for money.

Another successful scheme is commonly referred to as "drop box" or "mail drop." In this scheme, which was used in six of the seven cases⁷ according to investigators, subjects rented private mailboxes or drop boxes, set up bogus corporations, and opened phony corporate bank accounts. Subjects then used stolen, purchased, or otherwise obtained beneficiary and provider information to bill insurance plans for medical services and equipment not provided. Members of the criminal groups retrieved insurance checks from the drop boxes and deposited them into controlled bank accounts. Once deposited, proceeds were quickly converted to cash or transferred to other accounts and moved out of the reach of authorities. These activities sometimes continued even after subjects were indicted, arrested, or jailed.

The above-described activities affect consumers, beneficiaries, health care providers, and law enforcement officials. Consumers pay increased health care costs in the form of taxes, because taxpayer contributions support Medicare and Medicaid. In the case of private insurance, insured individuals pay increased premiums. According to investigators and doctors, false medical histories for some beneficiaries could affect the care prescribed, as the care could be based on false data. Beneficiaries also unknowingly risk exhaustion of their insurance benefits, due to false information included in the claims that use their names. Legitimate providers may find their reputations tarnished and their provider numbers suspended when investigators look into alleged fraud committed in the names of these legitimate providers. Such inquiry may also delay payment of their legitimate claims. Because of the multiplicity of schemes and the ease with which subjects move their operations from location to location, law enforcement officials find it difficult to keep up with this growing and widespread form of fraud and are often unable to seize or recoup fraudulent proceeds that are quickly moved out of their reach.

Criminals and Other Individuals With No Known Prior Criminal History Have Migrated to the Health Care Field

Criminals previously involved in other types of crime are now migrating into the health care fraud arena. In at least four of the seven cases we reviewed, some of the subjects had prior criminal records for crimes unrelated to health care, including securities fraud, narcotics violations, tax evasion, weapons violations, forgery, grand theft auto, and criminal boating violations. In one case, two of the subjects were on probation for non-health-care-related crimes at the time they committed the health care fraud. In three cases where there were no known prior criminal records, the individuals had connections to other criminal groups or individuals reportedly involved in health care fraud.

⁷ In the seventh case, the basic elements of the drop box scheme were used without the use of private mailboxes. In that case, the subject received fraudulent medical payments electronically.

B-283695

In the Illinois Medicaid case, an individual in New Jersey sent four individuals to Illinois to open a laboratory. When the group arrived in Illinois and purchased a lab, the previous lab owner had to teach them how to operate the lab and how to bill Medicaid and Medicare because the four had no prior experience operating medical laboratories. The group purportedly cashed the Medicaid insurance checks it received and forwarded them to the New Jersey individual. The investigator later found out that the New Jersey individual was under investigation for health care fraud.

We found other cases in which health care criminal groups were teaching health care fraud to others and expanding into other geographical areas. In the North Carolina Medicare case, three subjects residing in North Carolina traveled to Florida where relatives taught them how to anonymously file false Medicare claims. They then returned to North Carolina and began filing such claims. In one of the Florida private insurance cases, the investigator suspected the subject had learned how to commit health care fraud from two former employers who had previously been investigated for Medicaid fraud in South Florida.

In the cases we reviewed, according to investigators, the leaders of the groups had little or no known medical or health care education, training, or experience; and none possessed medical licenses.

Some of the individuals involved with the criminal groups investigated used relatives and associates in other countries to help them transfer fraudulently obtained money.

Criminal Groups Created Sham Medical Entities or Used Legitimate Medical Entities to Defraud Public and Private Health Insurance Systems

In six of the seven cases we reviewed, individuals in the criminal groups incorporated or otherwise set up as many as 160 medical clinics, physician groups, diagnostic labs, and/or DME companies to submit fraudulent or allegedly fraudulent public and/or private health insurance claims. In the seventh case, the subject used the names of four real clinics, but he changed their addresses on allegedly fraudulent claims so that payments would be mailed to private mailboxes that he controlled.

Typically, the leader of the group, in conjunction with others, would set up the medical facility by filing incorporation documents and obtaining state and federal certifications and provider numbers, where required, and, in some cases, taxpayer identification numbers (TIN). In two of the cases we reviewed, an actual physical location was set up for at least one of the companies established. For example, in the Illinois Medicaid case involving a laboratory, the subject paid 1 month's lease on office space and state-of-the-art medical testing equipment to obtain the certification needed to bill Medicaid for complex lab tests. Afterward, no patients were ever seen in the lab. In the Florida Medicare case, some clinics were opened to perform unnecessary diagnostic procedures on cooperating beneficiaries.

In most cases, however, the medical entities existed only on paper. To maintain anonymity, leaders of the groups frequently set up medical entities using fictitious names or the names of other group members, including relatives or associates. They sometimes fabricated identification cards by using their own picture but the name and identifying information of an uninvolved, unsuspecting individual. In one instance, the leader of the group opened companies in the names of individuals he met while serving time in prison. In the North Carolina Medicare case, the subjects searched for and found two individuals who wanted to leave the United States. The subjects paid each of the individuals \$100,000 for the use of their identities to set up corporations, bank accounts, and mail boxes and to obtain TINs, Medicare supplier numbers, and local licenses. Both individuals later left the country.

Once the framework was in place, subjects in the cases we reviewed used a variety of schemes to file claims with Medicare, Medicaid, and/or private insurance plans for medical services and/or equipment not provided or not medically necessary.

Criminal Groups Collaborated With or Used Beneficiaries, Physicians, and Clinics to Commit Alleged Health Care Fraud

In a scheme sometimes referred to as "rent-a-patient," recruiters organized beneficiaries to go to subjects' clinics for unnecessary diagnostic testing and/or medical services. The beneficiaries' insurance was billed for those services, and often for other services or medical equipment never provided. Licensed physicians sometimes participated in such schemes, typically exchanging their signatures on medical records for cash, without actually performing or overseeing any medical services, or providing Certificates of Medical Necessity (CMN)⁸ for DME equipment not provided or necessary.

In addition to recruiting willing beneficiaries and providers, members of these criminal groups purchased, stole, or otherwise obtained beneficiary, physician, and clinic information to bill insurance plans for medical services or equipment never provided in another scheme, referred to as "drop box," because the groups used private mailboxes to effectuate the scheme. In some cases, subjects attached fictitious doctor names to claims.

Use of Recruiters and Cooperating Beneficiaries

In two of the South Florida cases we analyzed involving Medicare and Medicaid fraud, recruiters organized and recruited thousands of beneficiaries from, among other places, low-income housing projects and retirement communities and drove them to area clinics for rote examinations and unnecessary testing, treatment, or DME referrals. Recruiters, predominantly elderly women in one case, generally received a fee of \$100 to \$125 for each

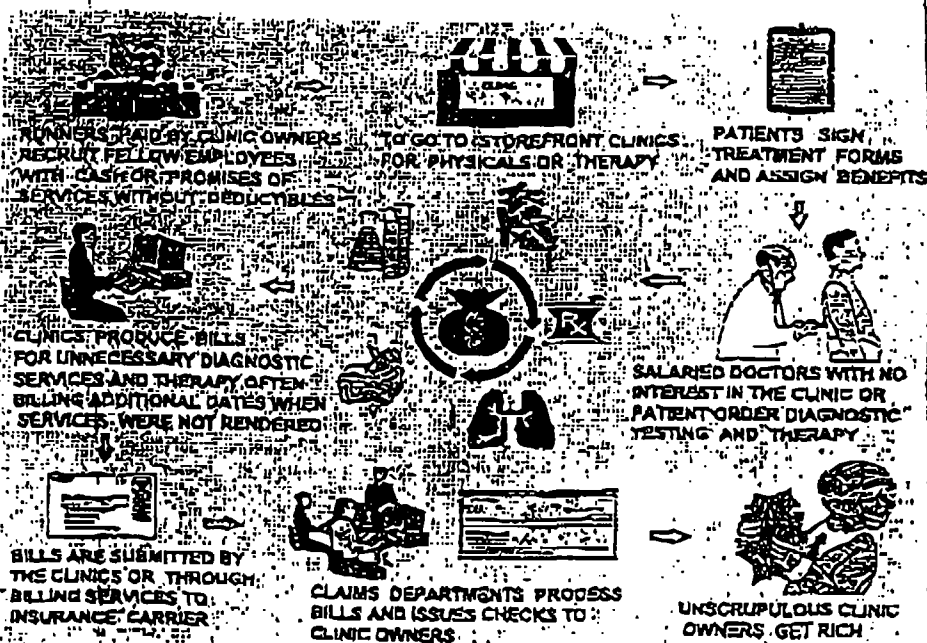
⁸ A valid CMN is required for the payment of Medicare claims for DME. A valid CMN is one that the treating physician has stamped and signed, supporting the medical need for the DME item, and on which appropriate individuals have completed the medical portion.

beneficiary they brought in. In turn, recruiters paid a portion of their fee to each cooperating beneficiary. Cooperating beneficiaries participated to "make a few bucks" and understood that if they needed "a real doctor," they were to go elsewhere.

In some cases, according to law enforcement officials, cooperating beneficiaries were known to have been solicited to go to a private apartment to have x-rays taken via portable x-ray units or to have blood drawn. The beneficiaries received cash or unneeded prescriptions, which they later filled and sold on the street. Their insurance plans were billed for x-rays, blood tests, or other unnecessary services or equipment.

In some cases, beneficiaries have been known to provide only their insurance (i.e., Medicaid) number in exchange for cash. A laboratory would later bill their insurance for blood tests it conducted using someone else's blood. Also, clinic owners would send blood samples to labs to conduct tests and bill Medicare or Medicaid, and the labs would "kick back" some of the money to the clinic owners. An official from the New Jersey State Attorney General's Office, Medicaid Fraud Section, stated, "Most [beneficiaries] know that their Medicaid card is better than a VISA card for getting money." In essence, under this scheme, beneficiary and/or identifying information is "rented" or "brokered" to subjects. (See fig. 1.)

Figure 1: "Rent-a-Patient" Scheme



Source: Florida Department of Insurance, Division of Insurance Fraud

Use of Cooperating Physicians and Physician Assistants

In two South Florida cases involving Medicare and Medicaid, some licensed medical doctors and several foreign medical school graduates, some of whom were certified physician assistants, cooperated in the schemes. In the Florida Medicare case, which involved clinics and DME companies, the medical school graduates and/or physician assistants performed the actual procedures, including administering noninvasive medical tests and filling out medical charts. Licensed physicians were then paid \$50 to \$100 per medical chart to periodically sign medical records for services they neither performed nor supervised or to provide referrals or CMNs for DME that was not needed. (See also fig. 1.) Although they signed for services purportedly performed by them or under their direction or observation, they were, in fact, not present when the services were performed.⁹

In the Florida Medicaid case involving DME companies, two clinic doctors were compensated for providing CMNs, which allowed the subjects to bill for unneeded oxygen concentrators through their DME companies.

Identities of Beneficiaries, Physicians, and Legitimate Clinics Used on Claims Without Their Authorization or Knowledge

Victim Beneficiaries

In all cases we reviewed, subjects used at least some "victim"¹⁰ beneficiary information that was purchased, stolen, or otherwise obtained to file false Medicare, Medicaid, and/or private insurance claims. These victim beneficiaries received no medical services or supplies, were not involved in the fraudulent and alleged fraudulent activity, were not aware their names had been used on the claims, and did not authorize the use of their identities on such claims. According to law enforcement authorities, the identities of an estimated 35 to 2,500 victim beneficiaries were compromised in each of the seven cases. Some beneficiaries learned of the fraudulent and alleged fraudulent claims when they received Explanation of Benefits (EOB), Explanation of Medical Benefits (EOMB), or Medical Summary Notice (MSN)¹¹ forms in the mail from the relevant insurer showing services or equipment they did not receive. Others learned of the fraud and alleged fraud when their insurer notified them about questionable claims filed or investigators contacted them looking into such claims. In the Illinois Medicaid case and one of the Florida private

⁹ The Medicare Carrier's Manual, Title B3, Section 2050 requires that the physician be physically present on the premises during the time of medical service for the service to be covered by Medicare.

¹⁰ In this letter, the terms "victim" beneficiaries, "victim" physicians, and "victim" clinics refer to uninvolved individuals or entities whose identities were used on fraudulent health care claims or other documents without their knowledge or authorization.

¹¹ The relevant payer sends EOBs, EOMBs, and MSNs to beneficiaries after a claim has been processed. Such statements list charges that have been billed to the insurer on the insured's behalf. Beneficiaries are encouraged to check such statements to be sure they were not billed for services, medical supplies, or equipment they did not receive.

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insurance cases, claims were filed for more than 17 beneficiaries who had died prior to the purported dates of medical service as shown on such claims. The claims were not paid.

- In some of the cases we reviewed, investigators told us they were able to tie several victim beneficiaries to a common hospital where all the beneficiaries had previously been treated, suggesting that someone in the hospital released beneficiary information to criminals.
- Providers in Charlotte, North Carolina, submitted Medicare claims for supplies and equipment purportedly provided to beneficiaries residing in South Florida upon orders of Charlotte-area physicians. In that case, the group leader had paid a relative—a physician at a Miami hospital—to obtain beneficiary lists from the Miami hospital. The relative was paid \$5 to \$7 per patient name.
- In the Illinois Medicaid case, the subjects fraudulently billed Medicaid using patient billing information they had legitimately obtained when they purchased a clinical laboratory from another individual.
- In the Florida Medicare case, an informant purchased copies of Medicare identification cards from a records clerk employed by legitimate doctors. The records clerk had first approached the informant about selling the identification cards when they became acquainted at a local bingo hall.
- During our review, a doctor in Miami, Florida, told us that his billing discs were stolen in an office burglary, while cash was left behind. The doctor told us that after the burglary, he received phone calls from patients about suspicious EOBs with his name attached to them for services he had not rendered. He further stated that other doctors in the same building and in another nearby professional building were burglarized in the same manner.
- In the Florida Medicaid case, the group leader's sister-in-law, who worked for a company that transported Medicaid patients, provided him with lists of beneficiary information.

In addition to the above examples, an investigator with a private insurance company told us that lists of beneficiary names and identifying information are known to have been sold illegally for \$50,000. We were also told that beneficiary information is sometimes stolen from hospitals or providers, taken from trash bins, or obtained by computer hackers.

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Victim Physicians and Clinics

In the same way that victim beneficiary information was used, victim provider information was also used in fraudulent health care claims. Victim physicians and clinics were not aware of the false claims; had not treated or referred the beneficiaries in question for the services or equipment shown; had not authorized the use of their identities; and, in many cases, did not even know the beneficiaries shown on the claims. Victim providers often became aware of such claims filed in their names when they received telephone calls from beneficiaries inquiring or complaining about EOBs they received showing medical services or equipment they had not received. In other cases, they learned about such claims only after being contacted by criminal investigators. In each of the 7 cases we reviewed, subjects used the names and identifying information of between 2 and more than 120 victim physicians as either the providing physician or the referring physician on the claims they submitted and on CMNs.

- In one of the Florida private insurance cases, the leader of the group allegedly used the names of four legitimate clinics as the providers of service on insurance claims. He simply changed the addresses of the clinics on the claim forms to a private mailbox he controlled.
- In a Florida private insurance case, the leader of the group allegedly used a victim doctor's name to file claims and to open a bank account the group leader controlled. To open the account, he presented the bank with a resident alien identification card bearing his photograph and the victim doctor's name; he also had a social security card bearing the victim doctor's name. Checks from this bank account were made payable to the leader of the group.
- In addition, in the case of one of the Florida private insurance investigations, victim doctors listed on claims as the "treating" physicians told investigators that they were not affiliated with the clinic or the physician group listed on such claims.
- Subjects sometimes obtained physician names and unique physician identification numbers (UPIN)¹² from unscrupulous hospital employees. In the North Carolina Medicare case, for example, a coconspirator who worked as an accounts receivable manager at a local hospital provided physician names and UPINs to the leader of the group. While executing a search warrant relative to the same investigation, investigating agents found a nationwide provider directory, which listed physician names and UPINs.

¹² Physicians and nonphysician providers who order or refer services, including lab work, for beneficiaries must submit their names and their UPINs on HCFA-1500 (Health Insurance Claim Form).

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An investigator from the Florida Division of Insurance Fraud told us that physician names and UPINs are readily available and showed us a physician telephone directory known as "The Little Blue Book," which lists physician names, addresses, specialties, and UPINs by county. The back of the directory includes an order form and a listing of all counties for which the directory is available, including metropolitan areas in most states. The investigating agents in the North Carolina Medicare case learned that nationwide provider names and UPINs can also be found on the Internet.

Fictitious Doctor Names Used on Claims

In two of the Florida private insurance cases, the investigators told us that the subjects also used the names of fictitious doctors on the claims they submitted. According to the investigator in one of the cases, the designation "M.D." followed fabricated names shown as the providers of services/billing entities on claims. The investigator determined there was no record of medical licensure under those names in the state of Florida.

Criminal Groups Used Third-Party Billing Companies, Private Mailboxes, and Bank Accounts to Defraud Medicare, Medicaid, and Private Insurance

In at least three of the investigations we reviewed, subjects used third-party billing companies to file fraudulent claims and receive payment. In one case, a factoring company¹³ was also used. Subjects sometimes defrauded more than one system. In six of the seven cases we reviewed, subjects used a "drop box" scheme, that is, they set up phony corporations, private mailboxes, and corporate accounts. Members of the criminal group would retrieve the insurance checks from the private mailboxes and deposit them into the bank accounts that they controlled. Once deposited, proceeds would quickly be converted to cash or moved to other accounts and moved out of the reach of authorities. Some of the subjects had associates or relatives who helped them transfer the ill-gotten proceeds. In the seventh case, subjects used the basic elements of the drop box scheme but received medical payments electronically rather than through the use of private mailboxes.

Submission of Claims

In the Florida Medicare case involving the use of clinics and recruited beneficiaries, the suspect's employees generated computerized Medicare claims using biographical data and the names of recruited beneficiaries. They then downloaded the information to tapes and delivered the tapes to a third-party billing company that entered the information into its own computer and sent it electronically to Medicare. Medicare generated a confirmation receipt that was forwarded to a factoring company, and the factoring company electronically advanced a predetermined percentage of the anticipated Medicare payment to the subject's bank account. The investigator on this case stated that although he

¹³ Factoring companies purchase the accounts receivable of a firm at a discount price, thereby providing the firm with immediate working capital.

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believes the third-party billing company started out as a legitimate company, the owner began to understand that it was more profitable to bill nonlegitimate claims. He ignored questionable claims from the subject even when the third-party billing company's employees raised concerns about the same beneficiary names repeatedly showing up on claims.

The Florida Medicaid case involved the use of two third-party billing companies to submit fraudulent claims for DME, namely oxygen concentrators. Individuals known to the subject operated both third-party billing companies and were aware that the claims were fraudulent. One of the third-party billing companies filed claims for DME for the subject based solely on beneficiary names and Medicaid numbers without required CMNs. When investigators asked the owner of the third-party billing company to produce the CMNs, she contacted the primary subject who, along with his associates, created the required CMNs. These fabricated CMNs were turned over to investigators the following day. (Subjects in one of the Florida private insurance cases used the same third-party billing company to file claims.)

Other subjects prepared fraudulent paper claims without the use of third-party billing companies. In the North Carolina Medicare case, the leader of the group prepared Medicare claims and related documents. After investigators questioned him about his retrieval of Medicare payments from a private mailbox, he disassembled the typewriter he had used to prepare the claims and instructed his daughter to dispose of the pieces. Later, when he thought he was no longer being closely scrutinized, he had his daughters and other neighborhood girls generate paper claims to private insurance plans from a home computer.

Billing of More Than One Insurance System

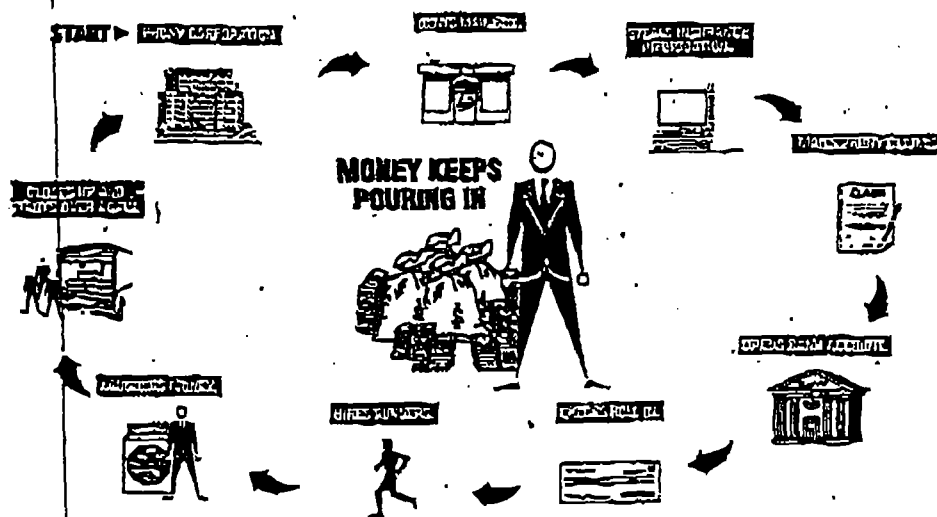
In at least three of the seven cases we reviewed, career and organized criminal groups defrauded more than one system (i.e., Medicare, Medicaid, or private insurance systems) simultaneously or moved from one system to another after they were caught in one area. For example, in the Florida Medicare case, subjects had filed in excess of \$120 million in fraudulent Medicare claims and \$1.5 million in fraudulent Medicaid claims. Because the investigator in the Medicare case had made a referral to Medicaid, Medicaid was able to stop the payment of the \$1.5 million in fraudulent Medicaid claims filed by the group.

In the North Carolina Medicare case, the leader of the group fled the country after being questioned by investigators about fraudulent Medicare claim payments. He returned to the United States a few weeks later and began submitting fraudulent health care claims to private insurance systems. This subject later told investigators that it was easy to get money from Medicare. However, according to the same individual, getting money from private insurers was so easy, it was "like stealing candy."

Use of Private Mailbox Facilities

To gain possession of insurance checks in payment of fraudulent health care claims, subjects in 6 of the 7 cases we reviewed had the checks sent to as many as 80 private mailboxes, or drop boxes. These mailboxes were opened at privately owned commercial mail receiving agencies (CMRA), including, among others, Mail Boxes Etc, A Mailbox for Less, and Pakmail Centers of America.¹⁸ Fraudulent and allegedly fraudulent claims listed the addresses for providers/billing entities as the CMRA addresses, with the actual mailbox numbers generally appearing on claims as suite numbers, building numbers, or office numbers.¹⁹ The group leader or other group members retrieved mail from these boxes. While some mail drop boxes were set up using the names of the group leader or cooperating coconspirators, others were set up using phony identification cards containing fictitious names or assumed identities along with photographs of the subjects. (See fig. 2.)

Figure 2: "Drop Box" Scheme



Source: Florida Department of Insurance, Division of Insurance Fraud

¹⁸ There is no indication that these CMRAs were involved in the fraud, except for the North Carolina Medicare case. In that case, the subject purchased his own Mail Boxes Etc franchise and began using its mailboxes to further his fraudulent activity while also retaining mailboxes at other uninvolved franchises.

¹⁹ A new CMRA regulation adopted by the U.S. Postal Service on Apr. 26, 1999, requires that all mail delivered to CMRAs be identified on its face as a private mailbox, or "PMB" (39 C.F.R. part 111 and *Domestic Mail Manual D042.2.6*). This regulation is meant to keep criminals from using CMRA addresses for credit card fraud and other scams. All CMRA customers must be in compliance by Apr. 26, 2000.

In one of the Florida private insurance cases where subjects operated within the Miami/Dade County area, 7 of 10 mail drop boxes were set up in other counties. The leader of the group paid the owners of the CMRAs in those locations to forward incoming mail, including checks representing payment of alleged fraudulent claims, to Miami/Dade County area mail drop boxes. The investigator explained that insurance companies know Miami is a "hot spot" for health care fraud activity and are less suspicious of claim payments going to addresses outside the Miami area. Mail drop boxes in other states were also tied to this group.

Use of Corporate Bank Accounts and Individuals to Transfer Money

In the cases we reviewed, fraudulently obtained funds were transferred in a variety of ways. Checks received at mail drop box locations and funds received electronically through billing companies were deposited into bank accounts that had been set up in (1) the names of the corporations, the subjects, the associates, or coconspirators or (2) fictitious or assumed names. Subjects then moved the money by cashing the insurance checks, writing checks to cash or individuals from bank accounts where insurance checks were deposited, and transferring funds between various corporate and individual bank accounts. Subjects sometimes used family members, friends, or associates in other countries to help them transfer their proceeds. In one case, a factoring company deposited claim payments electronically into bank accounts controlled by the subjects. According to an official of the New Jersey State Attorney General's Office, Medicaid Fraud Section, money laundering is the end result of most health care scams. Law enforcement officials find that assets are placed out of the government's reach before the fraud is discovered and documented and that money is sometimes moved out of the country.

In the North Carolina Medicare case, for example, the leader of the group opened corporate bank accounts in the names of two individuals to whom he had paid \$100,000 apiece for the use of their identities. He then transferred funds between bank accounts, with the majority of funds ultimately negotiated in the form of business checks to fictitious individuals. He had the checks shipped in blocks to family members and friends in Mexico via Federal Express and cashed by accomplices at banks in Mexico, including a Casa de Cambia (money exchange) where bank representatives converted the checks to U.S. and Mexican traveler's checks for a 5- to 8-percent fee. After deducting 10 percent for themselves, the accomplices shipped the remainder of the traveler's checks to the subject in the United States via Federal Express. The traveler's checks were subsequently spent or deposited to business or personal bank accounts. According to investigators, one of the subject's relatives in Mexico had a friend who worked in a Mexican bank. The friend would cash checks regardless of whose name was on them. In the same case, some of the funds sent to Mexico were converted to jewelry that was brought to the United States and resold by the group leader from his home.

In the Florida Medicaid case, the leader of the group paid family members and friends, including some he met while serving time in prison, to cash checks for him. In two of the Florida private insurance fraud cases, the leaders of the groups opened bank accounts in

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the names of legitimate, uninvolved providers, including a physician and four medical clinics whose names were used on allegedly fraudulent claims.

In another Florida private insurance fraud case, subjects deposited insurance checks to approximately 40 corporate bank accounts and then wired the money to European locations, through investment accounts. In the same case, an insurance official stated that her insurance company received cancelled insurance checks that had been cashed at a bank in Europe.

One subject in the Florida Medicare case directed his wife to send \$4.5 million overseas. The money was then transferred back into the United States through an alleged mortgage fraud scam involving politicians in Florida. Subjects in this case would not cooperate with government officials who were trying to determine the disposition and location of the ill-gotten proceeds.

Legal Actions Often Ineffective in Halting Fraud

Legal actions against suspects do not guarantee that the criminal activity will stop. An official of the New Jersey State Attorney General's Office, Medicaid Fraud Section, stated that organized criminal groups tend to be quite transient. He provided examples, unrelated to the seven cases we reviewed, that demonstrate this point. In one case, suspects fled to California and started new operations before they could be arrested for violations that had occurred in New Jersey. In other cases, his office closed down New Jersey clinics only to find out that the New York Medicaid Fraud Control Unit was investigating the same individuals for different schemes.

In the Florida Medicare case we reviewed, the subject conducted business from the federal detention center while awaiting sentencing by using the detention center's telephone system and personal identification numbers assigned to other inmates. From the phone, he directed his wife on how to run the health care fraud business in his absence.

In one of the Florida private insurance fraud cases, three indicted subjects are believed to have fled the country and are considered fugitives. Investigators received information, however, that indicates that this group continued to submit allegedly fraudulent medical insurance claims from Panama through a freight-forwarding company in Miami, Florida, which acts as a private mail facility and intermediary.

Impacts of Health Care Fraud Perpetrated by Career Criminal and Organized Criminal Groups

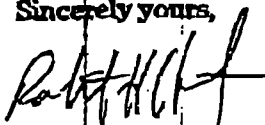
Consumers pay increased health care costs as a result of health care fraud. Taxpayer contributions support the Medicare and Medicaid programs, so all taxpayers are paying for

fraudulent claims paid by these programs. Also, additional health care costs to private insurers are passed on to insured individuals through increased premiums. Finally, self-insured companies risk going out of business when their health care costs become overwhelming due to fraudulent claims filed.

Beneficiaries, whose names are used on fraudulent claims, acquire false medical histories and risk exhaustion of their insurance benefits. Legitimate providers, whose identities are used on fraudulent claims without their authorization, may experience a variety of problems, such as delays in the payment of their legitimate claims, the receipt of IRS Forms 1099 for income never received, suspension of their provider numbers, or unearned tarnished reputations. Law enforcement officials find it difficult to keep up with this growing and widespread form of fraud and are often unable to seize or recoup fraudulent proceeds that are quickly moved out of their reach.

As agreed with your office, unless you release its contents earlier, we plan no further distribution of this letter until 90 days after the letter's date. At that time, we will send copies of this letter to interested congressional committees and will make copies available to others on request. If you have questions concerning the report, please contact Assistant Director Stephen V. Iannucci at (202) 512-6722. Special Agent Mary Balberchak was a key contributor on this assignment.

Sincerely yours,



Robert H. Hast
Acting Assistant Comptroller General
for Special Investigations

Enclosure

Enclosure I

Scope and Methodology

During this review, we examined the details of seven investigations wherein criminal groups representing themselves as legitimate providers fraudulently billed public and private insurance systems for medical services and equipment not rendered or not medically necessary. The investigations concerned fraud or alleged fraud committed in Florida, North Carolina, and Illinois with, in some cases, ties to other states and included two cases primarily involving Medicare, two cases primarily involving Medicaid, and three cases primarily involving private insurance systems, with some of these cases involving both public and private insurance systems. We selected these cases because they involved fraud and alleged fraud encompassing public and private insurance, different parts of the country, and significant dollar amounts in terms of fraudulent and allegedly fraudulent claims filed and paid and the significant number of victim beneficiaries.

We also interviewed federal and state law enforcement officials from the Federal Bureau of Investigation; Internal Revenue Service; U.S. Postal Inspection Service; Florida Division of Insurance Fraud; Office of the Florida State Attorney General/Medicaid Fraud Control Unit; Office of the New Jersey Attorney General/Medicaid Fraud Section; and State of Illinois/Medicaid Fraud Control Unit.

In addition, we interviewed officials of a private insurance company, including a health care fraud investigator, as well as two beneficiaries and two doctors whose identities were used on fraudulent claims without their authorization or knowledge. Further, we reviewed case-related and public-record documents and reports, as well as reports and statistical information relating to this type of health care fraud.

We conducted our review from August 1998 through September 1999, in accordance with quality standards for investigations set forth by the President's Council on Integrity and Efficiency.

(600487)



U.S. Department of Justice

Office of the Deputy Attorney General

Special Counsel for Health Care Fraud

Washington, D.C. 20530

August 13, 1999

To: Chris Jennings
Deputy Assistant to the President

From: John T. Bentivoglio 

Subject: GAO report on the Department's use of the civil False Claims Act in civil health care fraud matters

As you may know, the General Accounting Office recently released its report on the Department's use of the civil False Claims Act in health care fraud matters. Although the report acknowledged that the Department had made progress in implementing the June 1998 guidelines issued by the Deputy Attorney General, the report also criticized the Department's continuing investigations in the Lab Unbundling project. Significantly, most of the criticisms focus on actions taken before the issuance of the June 1998 guidelines.

While the Department agrees with some of the findings in the GAO report, we disagree with others. For example, GAO criticizes the Department for the slow pace of the Lab Unbundling investigations, yet the pace of the investigations has been delayed because DOJ generally has given hospitals the option to perform self audits, and many hospitals have taken advantage of this option.

Nonetheless, the Department has agreed to implement the two recommendations in the GAO report (relating to our evaluation and review system for US Attorneys' Offices) and to take additional steps – above and beyond the GAO recommendations – to improve our oversight process. **Appendix III** of the GAO report contains the Department's written response to the GAO findings. I have also enclosed a brief press statement, which provides further comment on the GAO report.

Finally, we understand the American Hospital Association has called on Congress to hold hearings on the GAO report in the fall. To date, we have not received formal notice of hearings, but we believe a hearing in the House is likely.

I hope this information is helpful. If you have any questions, please do not hesitate to contact me at (202) 514-2707.



U.S. Department of Justice

Washington, D.C. 20530

FOR IMMEDIATE RELEASE
Monday, August 9, 1999

**STATEMENT BY DEPARTMENT OF JUSTICE
SPECIAL COUNSEL FOR HEALTH CARE FRAUD JOHN BENTIVOGLIO**

**General Accounting Office report issued on DOJ implementation
of False Claims Act guidance in national health care initiatives**

"The Department of Justice concurs with many of the findings in the GAO report. The report documents the substantial progress we have made in providing strong oversight of our national enforcement projects. Each working group has developed a factual and legal review as required by the Deputy's June 3rd guidance, and is working closely with U.S. Attorneys' Offices. The GAO report also contains constructive recommendations with regard to our evaluation process, and we intend to implement these recommendations. In fact, we are taking additional steps -- above and beyond the GAO recommendations -- to enhance our oversight of national enforcement projects.

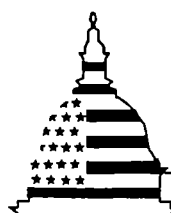
"With respect to the lab unbundling investigations, the GAO's findings about the pace of these investigations is not surprising. We have encouraged U.S. Attorneys' Offices to work cooperatively with hospitals in resolving these investigations, including providing hospitals with the option of conducting self audits. Many hospitals have chosen to conduct self audits. In addition, generally we have not relied on the use of traditional investigative methods -- including the issuance of civil investigative demands compelling the production of documents and testimony -- to establish evidence that false claims were submitted knowingly. We believe this more cooperative approach is the appropriate approach for resolving these investigations in a fair and even-handed manner."

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August 1999

MEDICARE FRAUD AND ABUSE

DOJ's Implementation of False Claims Act Guidance in National Initiatives Varies



G A O

Accountability * Integrity * Reliability



United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-282251

August 6, 1999

The Honorable Ted Stevens
Chairman
The Honorable Robert C. Byrd
Ranking Minority Member
Committee on Appropriations
United States Senate

The Honorable Orrin G. Hatch
Chairman
The Honorable Patrick J. Leahy
Ranking Minority Member
Committee on the Judiciary
United States Senate

The Honorable C. W. Bill Young
Chairman
The Honorable David R. Obey
Ranking Minority Member
Committee on Appropriations
House of Representatives

The Honorable Henry J. Hyde
Chairman
The Honorable John Conyers, Jr.
Ranking Minority Member
Committee on the Judiciary
House of Representatives

Improper billings to Medicare have been a longstanding threat to the fiscal integrity of the program. The Office of Inspector General (OIG) of the Department of Health and Human Services (HHS) estimates that overpayments due to billing errors, fraud, medically unnecessary services, and other problems totaled \$12.6 billion in fiscal year 1998.

With the increased attention to health care fraud and abuse in recent years, the Department of Justice (DOJ) has been using the False Claims Act (31 U.S.C. sec. 3729(a)-3733) for practices that in the past might have been dealt with by seeking repayment. The act's damages and penalties make it a powerful enforcement tool.

DOJ's efforts have included a series of nationwide investigations of hospitals. These national initiatives—as they are termed by DOJ—have been widely criticized by the hospital community.¹ Hospitals have alleged that they have been unfairly targeted and that DOJ has been overzealous in its application of the act. Responding to hospital and congressional concerns, DOJ issued guidance in June 1998 on the appropriate use of the act in civil health care matters, including national health care initiatives.

Concerns about DOJ's implementation of the guidance prompted the Congress to add a provision to the Omnibus Consolidated and Emergency Supplemental Appropriations Act of 1999 (P.L. 105-277) requiring us to monitor DOJ's and the U.S. Attorneys'² compliance with the guidance, including any revisions. We are required to issue two reports on the results of our work.

Our first report, issued in February 1999, focused on DOJ's early implementation of the guidance.³ We reported that DOJ had designated four national initiatives involving hospitals—Laboratory Unbundling, 72-Hour Window, Prospective Payment System (PPS) Transfer, and Pneumonia Upcoding—and had established work groups for each. We also noted that DOJ had begun taking steps intended to ensure that the 93 U.S. Attorneys comply with the guidance.⁴ For example, we reported that DOJ had incorporated the guidance into its training programs and was planning to include an assessment of compliance with the guidance in its ongoing reviews of the U.S. Attorneys' Offices. We also reported that the work groups—consisting of representatives from DOJ and selected U.S. Attorneys' Offices—had been established to support the four ongoing national initiatives. These work groups were then in various stages of preparing documentation, such as legal analyses and investigative plans, required by the guidance to assist the U.S. Attorneys' Offices participating in the initiatives. Our survey of all 93 U.S. Attorneys found that the majority were participating in at least one national initiative. Our survey

¹DOJ defines a national initiative as a nationwide investigation stemming from an analysis of national claims data, indicating that numerous similarly-situated health care providers have engaged in similar conduct to improperly bill government health care programs.

²U.S. Attorneys are supervised by the Attorney General but exercise a large degree of independence and discretion in the handling of their cases.

³See *Medicare Fraud and Abuse: Early Status of DOJ's Compliance With False Claims Act Guidance* (GAO/HEHS-99-42R, Feb. 1, 1999).

⁴These 93 U.S. Attorneys serve the nation's 94 federal judicial districts. One U.S. Attorney serves both the District of Guam and the District of the Northern Mariana Islands.

also found that several offices had closed a large number of investigations related to one initiative without taking actions against the providers.

This report summarizes the results of our monitoring of DOJ's and selected U.S. Attorneys' Offices' compliance with the guidance. Specifically, we (1) determined the status of the work groups' efforts and reviewed the initiative-specific guidance they prepared, (2) evaluated DOJ's efforts to assess U.S. Attorneys' compliance with the guidance, (3) examined implementation of the guidance at selected U.S. Attorneys' Offices, and (4) identified state hospital associations' concerns regarding DOJ's use of the False Claims Act.

In preparing this report, we conducted work at DOJ's Civil Division and its Executive Office of U.S. Attorneys and visited 10 U.S. Attorneys' Offices. Eight of the 10 offices were participating in at least one national initiative. Four of the 10 had been involved in large numbers of Laboratory Unbundling investigations but had closed them after DOJ's guidance was issued; we visited these offices to determine the reasons they had closed the investigations. The results of our visits to these four offices are described in appendix I. Finally, we surveyed state hospital associations regarding their views on DOJ's guidance and its implementation.

DOJ officials restricted our access to certain types of information at U.S. Attorneys' Offices because they believed public disclosure of this information could adversely affect pending law enforcement matters. For example, DOJ preselected materials from pending investigations, limiting these materials to those they considered relevant to our review. Furthermore, because investigations were pending, we could not obtain complete information about how the offices were planning and conducting their initiatives. We conducted our work between February and July 1999; except for the access limitations noted above, our work was performed in accordance with generally accepted government auditing standards. These limitations, however, did not have a material effect on the conclusions we reached in this report. For a complete discussion of our scope and methodology, including the limitations on our access to information needed to conduct our review, see appendix II.

Results in Brief

DOJ's national initiative work groups have made further progress in implementing the Department's False Claims Act guidance since we issued our February 1, 1999, report. All four work groups have completed their examination of the legal and factual basis for their initiatives and have

prepared initiative-specific guidance for the U.S. Attorneys' Offices participating in the initiatives. The guidance prepared by these work groups is consistent with the requirements in DOJ's guidance. For example, the guidance addresses the legal basis underlying each initiative and includes suggestions for conducting investigations of individual hospitals.

While DOJ officials told us compliance with its False Claims Act guidance is an ongoing priority for the Department, we believe DOJ's process for assessing the U.S. Attorneys' Offices' compliance may be superficial. In February 1999, DOJ began to include in its periodic reviews of U.S. Attorneys' Offices assessments of compliance with the guidance. These assessments, however, appear to involve little more than reviewers asking supervisors what they have done to ensure compliance with the guidance. Such limited efforts will not provide the information needed to adequately assess actual compliance. While we were not given access to the review results, DOJ officials told us that, as of June 25, only 2 of the 15 assessments that had been done contained any information about these offices' compliance with the guidance. DOJ's plans for strengthening the assessment process, such as adding more questions, may not be enough to effectively assess compliance. In our view, these additional questions will not provide more substantive information than the original question and are only a starting point for an effective assessment. Accordingly, we are recommending that DOJ take additional steps to improve its oversight of national health care initiatives.

We also found that the implementation of DOJ's False Claims Act guidance varied among the eight U.S. Attorneys' Offices we visited that were participating in the national initiatives. Five of these offices were participating in the Laboratory Unbundling initiative and had begun their involvement before DOJ's guidance was issued. We found that their actions were, to varying degrees, inconsistent with the guidance. Our limited review also raised questions about whether four of these offices were promptly incorporating the guidance into their ongoing investigations. While the 72-Hour Window initiative also started before DOJ's guidance was issued, our work at the one office that was conducting this initiative indicated that the office's actions were consistent with the subsequent guidance. We could not fully assess compliance at the offices we visited that were participating in DOJ's two newest national initiatives—PPS Transfer and Pneumonia Upcoding—because few investigations had started for either initiative nationwide. Nevertheless, based on our discussions with representatives from the two work groups and the offices, it appears that the initiatives are being developed in accordance

with the guidance. Restrictions on our access at all offices prevented us from conducting a complete and independent review.

Our survey of state hospital associations indicated that the issuance of DOJ's False Claims Act guidance has lessened their concerns about national initiative investigations. Half of the associations expressing concerns with DOJ's use of the False Claims Act prior to the issuance of the guidance said that the guidance had fully addressed their concerns.

Background

The False Claims Act provides that anyone who "knowingly" submits false claims to the government is liable for damages up to three times the amount of the erroneous payment plus mandatory penalties between \$5,000 and \$10,000 for each false claim submitted. The act defines "knowingly" to mean that a person (1) has actual knowledge of the false claim, (2) acts in deliberate ignorance of the truth or falsity of the information, or (3) acts in reckless disregard of the truth or falsity of the information. In the health care setting, where providers submit thousands of claims each year, the potential damages and penalties provided under the False Claims Act can add up quickly.

DOJ's use of the False Claims Act currently includes four national initiatives involving hospitals. The 72-Hour Window initiative, which began in 1995, centers on separate payments for outpatient services received within 72 hours of a hospital admission, which are paid as part of Medicare's inpatient reimbursement to hospitals. The Laboratory Unbundling initiative, which began in 1994 by U.S. Attorneys' Offices in Ohio, identifies excess payments for laboratory tests that were performed concurrently on automated equipment but improperly billed or "unbundled" as separate tests. In January 1999, DOJ announced two new national initiatives. The PPS Transfer initiative focuses on overpayments to hospitals that incorrectly report transfers to other hospitals as discharges in order to receive higher Medicare payments.⁵ The Pneumonia Upcoding initiative targets inappropriate coding of inpatient hospital billings for a form of the disease more costly to treat and paid at a higher rate than was supported by a patient's medical records.

⁵Under Medicare PPS, payment rates are established in advance and hospitals treating Medicare beneficiaries must generally accept the rate as full payment, regardless of the patient's length of stay.

In 1998, we reported that hospital groups had criticized DOJ's use of the False Claims Act in the two older national initiatives.⁶ They alleged that in both the 72-Hour Window and the Laboratory Unbundling initiatives, DOJ subjected many of the nation's hospitals to unwarranted investigations, resulting in large penalties for unintentional errors. In particular, the Laboratory Unbundling initiative provoked considerable controversy. The hospital groups complained that the initiative lacked a sufficient legal basis and relied on flawed data. They also charged that some U.S. Attorneys' Offices had issued demand letters threatening prosecution without sufficient evidence that the hospitals had submitted false claims.

On June 3, 1998, DOJ issued "Guidance on the Use of the False Claims Act in Civil Health Care Matters." The guidance emphasizes the fair and responsible use of the act in all civil health care matters, including all current and future national health care initiatives. It also instructs all DOJ attorneys to determine, before they allege violations of the act, that the facts and the law sufficiently establish that a claimant knowingly submitted false claims. The guidance requires them to take a number of steps, including reviewing relevant statutes and regulations and verifying the accuracy of the data relied on, to ensure that they support the allegations.

The guidance also contains new requirements specifically applicable to national initiatives. The guidance generally requires the U.S. Attorneys to use "contact letters" to notify providers of their potential exposure under the False Claims Act and to offer providers an opportunity to discuss the matter before a specific demand for payment is made. The new requirements also specify that a work group must be established for each current and future initiative. Work groups of Civil Division attorneys and Assistant U.S. Attorneys with expertise in health care fraud are expected to coordinate the development and implementation of the initiatives. The work groups are also expected to prepare "initiative-specific" guidance, such as a legal analysis of pertinent issues, a summary of relevant claims data, and an investigative plan to guide the U.S. Attorneys' Offices participating in the initiatives.

DOJ's False Claims Act guidance provided that it would be subject to review within a 6-month period. This review, completed in February 1999, clarified a number of issues in the guidance and also described how providers under investigation could elevate their concerns within the

⁶See Medicare: Application of the False Claims Act to Hospital Billing Practices (GAO/HEHS-98-195, July 10, 1998) and Use of False Claims Act to Target Hospitals (B-279893, July 22, 1998).

Department if they believed the guidance was not being followed. It also announced that national initiative work groups would be required to solicit and consider the views of HHS' OIG and other relevant agencies in conducting the initiatives. The review concluded that no major revisions to the guidance were necessary.

Work Groups Have Completed Initiative-Specific Guidance

At the time we issued our first report, only the Laboratory Unbundling and PPS Transfer work groups had completed preparing the required initiative-specific guidance. Since that time, the 72-Hour Window and Pneumonia Upcoding work groups have also finished their guidance. We examined the initiative-specific guidance prepared by the work groups and found that this guidance was consistent with the requirements outlined by DOJ for False Claims Act investigations. The confidential nature of these work group documents precludes us from discussing them in detail. However, we can make some general observations about each work group's initiative-specific guidance.

All the work groups have developed model contact letters for notifying providers that they were the subjects of False Claims Act investigations. We noted that these letters were carefully worded to avoid any inference that the providers had violated the False Claims Act. Unlike the demand letters previously used by some U.S. Attorneys' Offices, the new contact letters did not include a specific demand for payment nor, in our opinion, did they contain the type of language that many hospitals had found to be intimidating and coercive.

We found similarities between the documentation prepared by the Laboratory Unbundling, PPS Transfer, and Pneumonia Upcoding work groups. All three sets of documents elaborated on DOJ's general guidance and provided detailed steps for planning and conducting the initiatives. The documentation included an analysis of the legal basis underlying each initiative; however, we did not evaluate these analyses. All three sets of documentation included investigative plans containing specific suggestions for conducting investigations of individual hospitals. These plans also outlined procedures for determining whether claims submitted by these hospitals were false and, if so, whether the hospitals knowingly submitted them. In addition, the work group materials addressed the source, limitations, and reliability of the claims data to be used in the investigations. In our opinion, the documentation prepared by these three work groups was consistent with the requirements in DOJ's guidance.

The 72-Hour Window work group prepared a report that assessed the initiative's activities in light of DOJ's guidance, rather than the detailed guidance prepared by the Laboratory Unbundling, PPS Transfer, and Pneumonia Upcoding work groups. Unlike the other three national initiatives, which are being conducted by multiple U.S. Attorneys' Offices, a single U.S. Attorney's Office is conducting the 72-Hour Window initiative. For this reason, and because the initiative was more than two-thirds complete at the time DOJ's guidance was issued, this work group did not develop the same step-by-step instructions that were developed by the other three work groups. Nevertheless, we believe the report showed that the work group, as directed, had considered whether the initiative met the requirements established by DOJ's guidance. Among other things, it evaluated the accuracy of the data used in the initiative, the clarity of the relevant billing rules, and the appropriateness of the office's approach for completing the initiative. In our view, this report satisfies the requirement that work groups prepare initiative-specific guidance.

DOJ's Assessments of U.S. Attorneys' Offices' Compliance With the Guidance May Be Superficial

According to DOJ officials, the U.S. Attorneys' Offices' compliance with the guidance is an ongoing priority for the Department. However, DOJ's process for assessing compliance may be superficial. As we described in our first report, DOJ said that beginning February 1, 1999, it would include assessments of the offices' compliance with the guidance as part of the reviews it conducts at each office every 3 years. DOJ's assessments of compliance with the guidance during these periodic reviews of offices consists of a single interview question in which supervisors are asked to identify the steps being taken to ensure compliance. We believe these assessments provide little assurance that offices comply with the guidance.

According to DOJ officials, as of June 25, 1999, reviews incorporating this assessment were completed at 15 U.S. Attorneys' Offices. DOJ officials told us the reports on these offices were not yet complete; thus, they were unwilling to share them with us. They said that they had reviewed the draft reports or, if no draft report had yet been prepared, the reviewers' submissions. DOJ officials said that reviewers typically only report negative information. They also told us that the 15 draft reports or reviewer submissions contained no negative information about the offices' compliance with the guidance; in two cases, positive comments were made. For example, according to DOJ, one reviewer's report consisted of the following:

This [office] is in compliance with the requirements of the Deputy Attorney General's guidance on the use of the False Claims Act in health care fraud cases and matters. Training on the requirements has been provided to all ACE unit personnel.⁷

In response to our concerns about these reviews, officials told us that they would require reviewers to comment both negatively and positively on offices' compliance with the guidance in all future reviews. We do not believe that the two "positive responses," however, provided much insight about either of the offices' efforts to comply or their actual compliance because the comments were not specific. In our view, if the new requirement results in the reporting of similar information on all the offices assessed, these reports would not be meaningful.

In addition, the officials told us that, due to the importance of ensuring compliance, they had instructed reviewers to ask additional questions in future reviews. These questions ask whether an office has participated in any national initiatives since the office's last review and whether the office has complied with the guidance and the work groups' recommendations for conducting investigations. While these additional questions are relevant, we believe that they are only a starting point for an effective assessment and will not provide a more meaningful assessment of compliance than the original question.

DOJ officials told us that they were taking other steps, such as the following, to ensure that the guidance is followed.

- The Deputy Attorney General has emphasized the necessity of compliance both orally and in writing on a number of occasions and has encouraged U.S. Attorneys' Offices to document their compliance in investigative case files. We noted that three of the offices we visited had developed forms to document their compliance.
- Compliance with the guidance is a top priority of the Subcommittee on Health Care Fraud of the Attorney General's Advisory Committee. In this regard, the national initiative work groups are required to update the subcommittee on the status of each initiative on a regular basis.
- Work groups are expected to maintain regular contact with U.S. Attorneys' Offices participating in an initiative, monitor their progress, and provide guidance throughout the investigative and litigative processes.
- DOJ has assigned an experienced Civil Division attorney to each work group. DOJ officials believe that because these representatives specialize in

⁷Most U.S. Attorneys' Offices have ACE (Affirmative Civil Enforcement) units, which pursue civil actions to recover money lost due to fraud and other misconduct.

False Claims Act matters, their presence on the work groups helps ensure consistent adherence to Department policies concerning False Claims Act matters.

Implementation of Guidance by U.S. Attorneys' Offices Varies Among National Initiatives

DOJ's False Claims Act guidance applies to all national initiative health care investigations—including those ongoing at the time the guidance was issued. Our limited review showed that the offices' implementation of the guidance varied among national initiatives. Eight of the offices that we visited were participating in at least one of the national initiatives. Five of these offices began participating in the Laboratory Unbundling initiative before DOJ's guidance was issued. Our review raised questions about how promptly four of them were incorporating the guidance into ongoing investigations. While the 72-Hour Window initiative also started before DOJ issued its guidance, the one office conducting this initiative did not appear to be having difficulty implementing the guidance, and we were more convinced that this office was conducting the initiative in compliance with the guidance. We could not fully assess compliance at the offices participating in DOJ's two newest national initiatives—PPS Transfer and Pneumonia Upcoding—because few U.S. Attorneys' Offices, including those we visited, had started investigations for either initiative nationwide.

Table 1 shows the participation in the national initiatives for the eight U.S. Attorneys' Offices at the time of our visits. We are not identifying these offices or the exact number of their investigations because DOJ is concerned that doing so could compromise open investigations.

Table 1: U.S. Attorneys' Offices Visited Participating in National Initiatives

National Initiative	Number of offices
Laboratory Unbundling	5
72-Hour Window	1
PPS Transfer	3
Pneumonia Upcoding	5

Two of the eight offices had terminated their involvement in the Laboratory Unbundling initiative by the time of our visits. We also visited two other offices that decided to discontinue their participation in this project. These two additional offices were not involved in any other national initiative at the time of our visit. (For a discussion of the four offices' participation in the Laboratory Unbundling initiative and their decisions to terminate their involvement, see app. I.)

Implementation of Guidance Slow at U.S. Attorneys' Offices' Participating in Laboratory Unbundling

The five offices participating in the Laboratory Unbundling initiative had taken actions in their investigations prior to the issuance of DOJ's False Claims Act guidance that, to varying degrees, were inconsistent with the subsequent guidance. Generally, the five U.S. Attorneys' Offices we visited sent demand letters to large numbers of hospitals that alleged or implied violations of the False Claims Act. The letters warned that the hospitals could be liable for three times the amount of any overpayment plus penalties of between \$5,000 and \$10,000 for each false claim. The letters also presented the hospitals with an option: volunteer to conduct an independent self-audit and pay two times the amount of overpayments identified. However, contrary to the subsequent guidance, at the time these allegations were made, most of the offices had not sufficiently analyzed the claims data to determine if the pervasiveness and magnitude of the apparent errors were sufficient to warrant alleging a False Claims Act violation. Moreover, they also lacked evidence that each of the hospitals had submitted the alleged false claims knowingly.

Because DOJ's guidance applies to all health care investigations, including those ongoing at the time it was issued, these offices were faced with the task of determining what needed to be done to bring their investigations into compliance. We found that, more than 1 year after the guidance was issued, four of these offices had not completed actions to address the shortcomings in their ongoing Laboratory Unbundling investigations. Allegations that over 100 hospitals violated the False Claims Act remain unresolved at these four offices. The following provides more details related to our observations at these offices.

- In late 1997, one U.S. Attorney's Office notified about two dozen hospitals that they were under investigation because the office had identified certain claims that may have been submitted in violation of the False Claims Act. However, officials told us in March 1999 that these hospitals had actually been selected primarily because they were the largest billers of Medicare in the state, not because the office had evidence that they were unbundling laboratory claims. They acknowledged that their selection methodology was inconsistent with DOJ's guidance but told us that they had subsequently obtained data showing that all of these hospitals had submitted significant numbers of unbundled laboratory claims to Medicare. We could not verify their statement because, citing the pending nature of the investigations, officials declined to share the data with us. In June 1999, more than a year and a half after beginning their investigations and 1 year after DOJ's guidance was issued, these officials told us that they had recently begun a detailed analysis of billing data on

each of the hospitals. The analysis, while not completed, indicated that at least one of the hospitals should not be pursued for violating the False Claims Act. Other hospitals could be dropped from the investigation once their analysis is completed, they said. In addition, DOJ officials told us in July that the office, which had never before provided the hospitals with any of the evidence it had compiled against them, planned to share excerpts of the data indicating they had improperly billed Medicare.

- Officials at another U.S. Attorney's Office acknowledged making False Claims Act allegations against 75 hospitals in 1997 before obtaining sufficient evidence to support the allegations, as the guidance now requires. Officials told us that they did not know if these hospitals had knowingly submitted false claims at the time they made the allegations. Investigations against some of the hospitals were dropped after further analysis by the office indicated that the estimated overpayments to them were small. In addition, responding to the hospitals' concerns about the cost of the proposed self-audits, most hospitals were later given the opportunity to accept the office's estimate of the false claims plus damages in lieu of an audit. At the time of our visit in April 1999, however, over 60 of the investigations remained unresolved. Because the investigations were pending, officials would not discuss them. They did indicate, however, that opening so many investigations at the same time had strained their resources and, as a result, establishing whether all of these hospitals had knowingly submitted false claims—a step now required before alleging False Claims Act violations—would be time-consuming and difficult. In July 1999, officials told us that all of the investigations were still pending and they did not know how long it might take to resolve them.
- In 1997, another U.S. Attorney's Office alleged that about 10 hospitals had violated the False Claims Act, but the office lacked evidence that the claims were false—let alone that the hospitals were knowingly submitting false claims. The allegations were based on a computer analysis of claims data that indicated these hospitals had received the largest overpayments from unbundling laboratory services. At the time of our May 1999 visit, all these investigations were pending. The majority of the hospitals had completed self-audits, but self-audits of the remaining hospitals had not yet started. According to the officials, all of the completed audits found insignificant billing errors that could not, in their view, support a False Claims Act case. Officials conceded that investigations against some, maybe all, of these hospitals might not have been started had they done a better analysis of the claims data, as now required by DOJ's guidance. Nevertheless, a DOJ official told us in July 1999 that investigations of the remaining hospitals will continue.

- In 1997, another U.S. Attorney's Office sent letters to about three dozen hospitals in the state alleging that the hospitals might have submitted false claims and asking them to volunteer to conduct self-audits of their laboratory billings. At this time, however, the officials had not verified the accuracy of the data they were relying on to support this allegation, nor did they have information showing that false claims were knowingly submitted. The office did not initially respond to hospital requests that it provide the data supporting its allegations of false claims. When some hospitals did not promptly decide whether to volunteer for self-audits, they were warned that the government would seek the full penalties of the False Claims Act if the office did the audits itself. The office continued to assert that hospitals had submitted false claims. For example, in a late 1997 letter to an attorney representing one of the hospitals, the office said it did not consider the matter to be a mere overpayment case. Rather, the letter said that the office would agree to settle the case for an amount equal to twice the overpayment, absent extenuating circumstances. Ultimately, the office obtained additional data that revealed that the original data used to select the hospitals for investigations had apparently overstated the hospitals' billing errors. In late 1998, more than a year after the investigations had begun, the office concluded that about one-fourth of the hospitals should not be pursued for False Claims Act violations. At the time of our May 1999 visit, officials told us that they were developing overpayment estimates for the remaining hospitals. In July 1999, a DOJ official told us that a few additional investigations had been resolved but the office was attempting to collect evidence from the remaining hospitals in order to prove the "knowing" element necessary to establish that the claims were false.

The fifth U.S. Attorney's Office sent letters to about 75 hospitals—virtually all the acute care hospitals in the office's jurisdiction—alleging that they had submitted false claims. Based on our review, this office appeared to have stronger evidence than the other offices that some of these hospitals had knowingly submitted false claims because they had been repeatedly identified in Medicaid audits and investigations as having unbundled laboratory services. At the time of our visit, the majority of the office's investigations had been settled and over \$5 million had been recovered. However, over 40 percent of these settlements involved only the recovery of the overpayments without False Claims Act damages or penalties being assessed.

Implementation of Guidance at U.S. Attorney's Office Leading 72-Hour Window Initiative Appears Appropriate

The 72-Hour Window initiative, like Laboratory Unbundling, began before DOJ issued its False Claims Act guidance. Officials at the one office conducting the 72-Hour Window initiative told us that they believed that actions taken in their investigations were consistent with the guidance. Our review of selected closed case files found no compelling evidence to dispute the officials' assertions. Consequently, despite limitations on our access, we were more convinced that this office was conducting the initiative in compliance with the guidance than we were at offices involved in the Laboratory Unbundling initiative.

Our review of closed files showed that the office had sent letters to the hospitals alleging that they had violated the False Claims Act and providing an estimate of their total financial exposure under the act. The hospitals were offered an opportunity to settle these matters before litigation by paying lesser amounts. The case files contained overpayment data that the officials told us had been developed from an audit conducted by HHS' OIG. These data formed the basis for the office's allegations that the hospitals had submitted false claims. Moreover, this audit was the fourth in a series of audits going back to 1983 that showed that thousands of hospitals had repeatedly violated the 72-Hour Window. In addition, they told us that the three prior audits along with the recovery of overpayments identified in those audits clearly put the hospitals on notice of the billing rule. The officials believed that the hospitals' continued submission of improper claims after these audits was a strong indicator that the hospitals were "knowingly" submitting false claims.

We did note, however, that some investigations that were pursued as False Claims Act violations before DOJ's False Claims Act guidance was issued involved small dollar amounts. The guidance requires offices to consider the pervasiveness and magnitude of the improper billings in assessing whether the false claims were knowingly submitted rather than mere mistakes. Officials told us that the pervasiveness and magnitude of improper billings would be taken into account in future investigations.

Implementation of Guidance Cannot Be Fully Assessed at U.S. Attorneys' Offices' Participating in the PPS Transfer and Pneumonia Upcoding Initiatives

We could not fully assess compliance with DOJ's False Claims Act guidance at the U.S. Attorneys' Offices we visited that were participating in the two newest national initiatives—PPS Transfer and Pneumonia Upcoding. Most investigations related to these initiatives were pending at the time of our visits and, consequently, our access to information related to both initiatives was restricted. Moreover, only a few PPS Transfer investigations had been started and none of them had progressed very far. Further, many of the pending Pneumonia Upcoding investigations were related to a qui tam lawsuit,⁸ which we agreed to exclude from the scope of our review. While we could not fully assess compliance with the guidance, based on our work, it appears that these two initiatives are being developed in accordance with DOJ's guidance.

While DOJ's PPS Transfer national initiative has been under development since late 1997, only a few U.S. Attorneys' Offices are currently participating in the initiative, and investigations of individual hospitals by these offices are just beginning. We visited three of these offices. Shortly before our visits, two of the offices had sent several hospitals contact letters notifying them that they were under investigation. Officials at the third office told us they had recently completed analyzing data on one hospital, had concluded an investigation was warranted, and planned to send the hospital a contact letter soon. Other than showing us redacted copies of the contact letters and, in one instance, a redacted copy of the hospital's response, officials at the three offices told us they could not provide any other information about these pending investigations.

DOJ's Pneumonia Upcoding initiative was established to determine whether certain hospitals referred by HHS' OIG had violated the False Claims Act by upcoding pneumonia claims. But investigations of hospitals referred by the OIG had not started at the offices we visited. Five of the offices, however, were involved in investigations of pneumonia upcoding at 19 other hospitals. All but two of these investigations were pending at the time of our visits; therefore, our access to information about these cases was restricted. Moreover, many of the pending investigations were related to a qui tam lawsuit and thus, as discussed further in appendix II, these were outside the scope of our review. At two offices, we were provided some documents related to several pending investigations that did not involve qui tam lawsuits. At a third office we examined materials associated with one of the closed investigations—not enough information,

⁸A qui tam lawsuit involves an action brought by an individual on behalf of the United States alleging that false or fraudulent claims have been submitted to the government.

in our opinion, to be able to reach conclusions regarding these offices' implementation of the DOJ guidance.

DOJ's Guidance Appears to Have Lessened State Hospital Associations' Concerns

Of the 39 state hospital associations responding to our survey, 34 indicated they were concerned with DOJ's use of the False Claims Act prior to the issuance of the guidance. Seventeen of the 34 reported that the guidance fully addressed these concerns, and 2 said they were not sure. The remaining 15 reported concerns reflecting a range of issues. But no single concern was shared by a majority of these associations. For example, six associations told us that they believed that the guidance should have established a minimum threshold of alleged overpayments before a False Claims Act investigation would be initiated. One association charged that the guidance is vague enough to allow DOJ to characterize intimidating and unfair use of the act as compliance with the guidance.

Eight state hospital associations reported that they did not believe the guidance was being followed in an ongoing national initiative in their state. In all but one of these responses, the concerns raised were related to the Laboratory Unbundling initiative. The most often voiced criticism was that this initiative lacked a legal basis.⁹ These eight state hospital associations also mentioned a variety of other concerns related to the Laboratory Unbundling initiative. For example, they criticized U.S. Attorneys' Offices for using questionable data, alleging False Claims Act violations based on these data, and requesting the hospitals to assist in the investigations by conducting self-audits.

Conclusions

One of DOJ's most important weapons in the fight against health care fraud is the False Claims Act. As with all enforcement tools, it is important that the law be fairly applied. Questions about the appropriateness of DOJ's use of the act in national initiatives led to the issuance of DOJ's False Claims Act guidance. DOJ has made progress in implementing the guidance since it was issued last year. The materials the work groups have prepared to guide U.S. Attorneys' Offices provide detailed steps for planning and conducting the initiatives. In our view, these materials are consistent with the guidance and are designed to avoid actions that offices previously took that would not have met the guidance's requirements. DOJ also appears to be developing the two newest national initiatives—PPS Transfer and Pneumonia Upcoding—in a manner that is consistent with the guidance. In

⁹As previously stated, we did not evaluate the legal merits of any of DOJ's national initiatives, but we did verify that DOJ has performed a legal analysis for the Laboratory Unbundling initiative.

addition, our limited review at the one office conducting the 72-Hour Window initiative suggested that little would need to be changed to incorporate the guidance into the initiative. However, four of the five U.S. Attorneys' Offices we visited that were participating in the Laboratory Unbundling initiative had not completely incorporated the guidance into investigations they had started before the guidance was issued.

DOJ's assessments of the U.S. Attorneys' Offices' compliance with the guidance, as now performed, appear superficial. Although DOJ intends to enhance these reviews, we do not believe that the proposed enhancements will provide more useful information about the offices' compliance. Given the importance DOJ says it places on the guidance, we believe that its monitoring of U.S. Attorneys' Offices should provide DOJ management with specific information on the offices' compliance efforts and the results of these efforts. Such assessments should involve more than asking questions about an office's compliance; it should also include verification of this compliance.

Recommendation

We recommend that DOJ improve its oversight of U.S. Attorneys' Offices participating in national health care initiatives. Specifically, DOJ should

- develop guidance for reviewers that includes specific steps for determining whether offices appropriately follow the guidance and
- require reviewers to independently determine whether the offices are complying with the guidance.

Agency Comments

We provided DOJ a draft of this report. In written comments, the Department generally agreed with our findings and said it would implement our recommendations. In addition, DOJ said it would give special attention to U.S. Attorneys' Offices where the Laboratory Unbundling initiative was ongoing at the time its False Claims Act guidance was issued. As an initial step, DOJ plans to require these offices to document their compliance with the guidance.

DOJ also offered comments in response to our concerns about the Laboratory Unbundling initiative. These comments revolved around two issues: (1) the timeliness of incorporating the guidance into ongoing investigations and (2) the adequacy of the evidence used as a basis for alleging False Claims Act violations.

Concerning the first issue, DOJ said that a number of factors have affected the speedy resolution of Laboratory Unbundling investigations. In particular, it said that investigations have proceeded with caution to ensure that errors made in the past are not repeated. DOJ also explained that, in many cases, hospitals have requested extensions to allow for further review of claims data and that these requests have been granted. While we agree that offices should proceed cautiously and that it is reasonable to grant time extensions, we are uncertain about the extent to which the slow progress in these investigations is attributable to these factors. For example, as we described in the report, more than 1 year after the guidance was issued, one office had only recently begun a detailed analysis of hospital billing data. Also, as mentioned in the report, officials at another office attributed their slow progress to having opened too many investigations at the same time. According to these officials, the volume of pending investigations had strained their resources, making it difficult and time-consuming to bring these investigations in compliance with the guidance.

Concerning the second issue, DOJ questioned our contention that some of the offices we visited had alleged violations of the False Claims Act before obtaining sufficient evidence. DOJ acknowledged that one office had sent letters to hospitals discussing possible False Claims Act violations prior to obtaining evidence that false claims had been submitted by these hospitals. However, DOJ said that the other offices contacted hospitals only after examining several years of claims data that had suggested claims were improperly submitted. We agree these offices had some data that suggested that unbundling of laboratory services could be occurring. However, the offices used these data as a basis for alleging that numerous hospitals had violated the False Claims Act. As discussed in the report, at the time these allegations were made, most offices had not adequately analyzed the data to determine if the apparent errors were sufficient to warrant a false claims violation, as DOJ guidance now requires. We also found that these offices lacked evidence that each of the hospitals had submitted false claims knowingly.

Finally, DOJ said that self-audits have always been, and remain, a voluntary option for hospitals. DOJ expressed concern with a statement in our draft report that one office was requiring hospitals to conduct self-audits. We recognize that the self-audit approach is a voluntary option and we revised the report accordingly. We have included the Department's comment letter as appendix III.

We are sending copies of this report to the Honorable Janet Reno, Attorney General of the United States, officials from the organizations we visited, and other interested parties. We will also make copies available to others upon request. Please call me at (202) 512-7114 or Leslie G. Aronovitz at (312) 220-7600 if you or your staff have any questions about this report. Other major contributors to this report include Paul D. Alcocer, Barry R. Bedrick, Stefanie G. Weldon, Robert T. Ferschl, and Geraldine Redican-Bigott.

A handwritten signature in black ink that reads "William J. Scanlon". The signature is written in a cursive style with a large, stylized 'S'.

William J. Scanlon
Director, Health Financing and
Public Health Issues

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Abbreviations

ACE	Affirmative Civil Enforcement
DOJ	Department of Justice
EOUSA	Executive Office for U.S. Attorneys
HHS	Department of Health and Human Services
OIG	Office of Inspector General
PPS	prospective payment system

Data Problems Led to Termination of Laboratory Unbundling in Illinois and Texas

In our February 1999 report, we discussed the results of our survey of all the U.S. Attorneys' Offices. We reported that some offices closed large numbers of Laboratory Unbundling investigations after DOJ's False Claims Act guidance was issued, without taking adverse actions against providers. We also said we planned to determine the reasons for the seemingly large number of Laboratory Unbundling declinations in preparation for this report. The majority of these declinations—more than 85 percent—involved U.S. Attorneys' Offices in Illinois and Texas. These offices had also reported they were no longer involved in Laboratory Unbundling.

The three U.S. Attorneys' Offices in Illinois and the four U.S. Attorneys' Offices in Texas pursued Laboratory Unbundling investigations on a coordinated basis in their respective states. The investigations began in 1996 in Illinois and in 1997 in Texas. At their peak, more than 100 investigations were under way against Illinois hospitals, while about 300 hospitals were under investigation in Texas. We visited two offices in each of these states.

We observed that these four offices—like the other offices we visited that were continuing with their Laboratory Unbundling investigations as discussed in our letter—had taken actions during their investigations that would no longer be permitted by DOJ's guidance. For example, the offices sent demand letters to the hospitals alleging that the hospitals had unbundled laboratory claims in violation of the False Claims Act. However, the offices had not adequately verified or analyzed the data they were relying on as a basis for their allegations and they also lacked evidence that any false claims had been “knowingly” submitted by the hospitals. The key difference between the Illinois and Texas offices and the offices that are continuing with Laboratory Unbundling appeared to be related to the accuracy and reliability of the data supporting the False Claims Act allegations. In Illinois and Texas, these data were seriously flawed. The other offices did not appear to have such serious data problems, but we could not be sure in all instances because of limitations on our access to this information.

The allegations against Illinois and Texas hospitals were based on claims data obtained from the local fiscal intermediaries,¹⁰ and the hospitals were provided with either computer disks or printouts listing claims the offices believed had been unbundled. This claims data, however, had not been adequately analyzed and verified before the offices made their allegations.

¹⁰Fiscal intermediaries are private insurance companies that contract with the government to pay Medicare claims for services from hospitals and certain other health care providers.

Appendix I
Data Problems Led to Termination of
Laboratory Unbundling in Illinois and Texas

When hospitals reviewed the data, they found what they believed to be a variety of errors. Follow-up by the U.S. Attorneys' Offices confirmed that the data were indeed flawed. Offices in both states made adjustments to their overpayment estimates on the basis of partially corrected fiscal intermediary data, but not all of the errors could be readily corrected. Primarily because of the unreliability of the data, both the Illinois and Texas offices ultimately concluded they had no alternative but to withdraw their allegations of False Claims Act liability against the hospitals and terminate their involvement in the initiative.¹¹

¹¹Three of the offices told the hospitals they were referring the matters to the local fiscal intermediary for possible collection of some of the amounts. The other office reached an agreement with the hospitals it was investigating whereby the hospitals agreed to repay an adjusted amount to the fiscal intermediary without damages or penalties. At the four offices we visited, hospitals that had previously settled—5 in Illinois and 19 in Texas—were refunded the amounts they had paid as part of their settlement agreements. In addition, one Texas hospital opted not to rescind its settlement agreement. A refund to another Texas hospital, which was involved in bankruptcy proceedings, had not been made at the time of our visit.

Scope and Methodology

To monitor DOJ's compliance with its False Claims Act guidance, we met with officials from the Civil Division and the Executive Office for U.S. Attorneys (EOUSA). In addition, we met with representatives from the work groups that have been established to support the four national health care initiatives. We also visited 10 U.S. Attorneys' Offices to discuss the offices' participation in the national initiatives; their implementation of the guidance; and, in four cases, their decisions to terminate their involvement in the Laboratory Unbundling initiative.

We used the results of our survey of all U.S. Attorneys' Offices, discussed in our first report, to judgmentally select the 10 locations. Six of the 10 offices were chosen because they had significant numbers of pending investigations related to at least one of the national initiatives. In addition, four offices were selected primarily because they reported closing large numbers of Laboratory Unbundling investigations without adverse action against the providers. These four offices were no longer participating in the Laboratory Unbundling, but two of them were participating in other national initiatives at the time of our visit. Thus, in total, we visited eight offices that were actively involved in at least one of the national initiatives.

We stated in our first report that DOJ was unwilling to give us access to information relating to its use of the False Claims Act that we needed to assess compliance with the guidance. At that time, DOJ would not give us access to certain work group documents and deleted or "redacted" portions of other documents. In addition, DOJ would not allow us access to documents related to ongoing investigations. DOJ deemed this information confidential and feared that public disclosure could potentially compromise these investigations.

For this review, DOJ officials agreed to expand our access, provided that we not disclose the contents of these documents. We agreed and, consequently, were permitted to examine unredacted versions of the work group documents. We were also allowed access to some documents related to pending national initiative investigations at U.S. Attorneys' Offices. However, DOJ officials preselected these documents and limited them to those that they considered relevant to our review. In addition, while we routinely obtain copies of documents in our reviews, DOJ would not permit us to have copies of any of these materials. In most cases, we were allowed to take handwritten notes, but this was a time-consuming process that may have interfered with our ability to monitor the offices while we were there. Moreover, while we normally have independent access to officials outside of an agency's headquarters, DOJ would not

permit us to interview or contact officials from U.S. Attorneys' Offices unless a representative from EOUSA was present. Likewise, we were not permitted to meet with work group representatives without an EOUSA official in attendance. For these reasons, we cannot say with certainty that we have all of the information necessary to conduct a complete and independent review of U.S. Attorneys' compliance with the guidance.

Our access was also limited by the existence of qui tam or "whistleblower" lawsuits, which, DOJ officials told us, involved the majority of pending investigations related to one of the national initiatives—Pneumonia Upcoding. Such lawsuits are typically filed under seal allowing DOJ to investigate without the defendant's knowledge. DOJ officials told us the seal prohibits them from disclosing information about such cases. Consequently, we excluded pending qui tam investigations from the scope of our review. By doing so, however, our ability to monitor U.S. Attorneys' Offices' compliance with the Pneumonia Upcoding initiative was limited.

In performing our work, we did not attempt to assess DOJ's legal basis for alleging that hospitals had violated the False Claims Act, nor did we attempt to verify the accuracy of the data used by DOJ in making these allegations. In addition, while DOJ's False Claims Act guidance applies to all civil health care fraud and abuse investigations, we limited our review to those investigations that were related to the four designated national initiatives.

We surveyed hospital associations from all 50 states as well as the District of Columbia and Puerto Rico to obtain their views on DOJ's False Claims Act guidance and its implementation in national initiatives. We also met with representatives from a state association and from the American Hospital Association.

We performed our work between February and July 1999. Except for the access restrictions discussed above, our work was performed in accordance with generally accepted government auditing standards. These limitations, however, did not have a material effect on the conclusions we reached in this report.

Comments From the Department of Justice



U.S. Department of Justice

Office of the Deputy Attorney General

Special Counsel for Health Care Fraud

Washington, D.C. 20530

July 30, 1999

Mr. Paul Alcocer
Assistant Director
Health Financing and Public Health Issues
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Alcocer:

Thank you for sharing with the Department of Justice (DOJ) the draft report prepared by your office entitled Medicare: Variations in DOJ's Implementation of Its False Claims Act Guidance in National Health Care Initiatives (GAO/HEHS-99-170). We appreciate the opportunity to provide comments.

Generally, we agree with many of the findings outlined in your report. In particular, as you indicate, since the General Accounting Office (GAO) issued its initial report on February 1, 1999, DOJ's national initiative working groups have made substantial progress in implementing the Department's June 3, 1998, False Claims Act guidance (June 3rd guidance). All four working groups have conducted a comprehensive analysis of the legal and factual basis for its national initiative and prepared initiative-specific guidance for use by participating United States Attorneys' offices (USAOs). We concur with GAO's finding that the working group materials for each of the four national initiatives are consistent with the requirements in the June 3rd guidance.

As noted in your report, the Department has taken a number of affirmative steps to ensure that USAOs are complying with the June 3rd guidance. The Deputy Attorney General has emphasized the importance of following the guidance on a number of occasions and remains committed to ensuring that the False Claims Act is applied in a fair and responsible fashion. In supplemental guidance issued December 4, 1998, and February 3, 1999, the Deputy Attorney General emphasized again that all Departmental attorneys are expected to comply with the June 3rd guidance. Moreover, the Attorney General's Advisory Committee, through its Subcommittee on Health Care Fraud, actively monitors the progress of each initiative and regularly meets with national initiative working groups for status updates. Working groups comprised of Assistant United States Attorneys (AUSAs) and Civil Division Trial Attorneys are working closely with USAOs participating in national initiatives and are providing guidance throughout the investigative and litigative process.

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Additional steps have also been taken by the Department to ensure that the June 3rd guidance is followed. For example, the Department has provided substantial assistance to its attorneys on the application of the June 3rd guidance in more than twelve formal training courses or seminars. Both the Civil Division and the Executive Office for United States Attorneys (EOUSA) have incorporated the June 3rd guidance into their training curriculum. Additionally, experienced Health Care Fraud Coordinators in the Civil Division and in EOUSA are available to respond to questions regarding application of the guidance. Further, members of the working groups speak regularly with USAOs that work on national initiative investigations, obtain updates on the progress of those investigations, and provide advice and guidance on subjects such as data analysis, investigative process and settlement issues.

The report contains several constructive suggestions for strengthening our efforts to ensure that all matters and cases are handled in accordance with the June 3rd guidance. Specifically, the report recommends that DOJ improve its oversight of USAOs by (1) developing guidance for reviewers that includes specific steps for determining whether offices appropriately follow the guidance, and (2) requiring reviewers to independently determine whether the offices are complying with the guidance. The Department will take steps to implement both of these recommendations. Moreover, we recognize that the transition districts discussed in the report, i.e., the districts where the laboratory unbundling national initiative was ongoing at the time of the June 3rd guidance, require special attention. We will be taking additional steps above and beyond those recommended by GAO to ensure that these transition districts are in full compliance with the June 3rd guidance. As an initial step, these districts will be required to document their compliance with that guidance, as suggested in the Deputy Attorney General's memorandum on compliance with the June 3rd guidance, issued December 4, 1998.

With regard to the districts participating in the laboratory unbundling project discussed on pages 10 - 12 of the draft report, we appreciate the opportunity to address the primary concerns outlined in your report. Your report indicates that some offices have not completed actions to address shortcomings in laboratory unbundling investigations.

Districts have diligently worked to allow hospitals every opportunity to analyze data and present mitigating evidence and/or defenses for consideration. With respect to GAO's perception that some offices have not moved expeditiously to conclude ongoing investigations and reach settlements, a number of factors have impacted the speedy resolution of laboratory unbundling investigations. In part, the progress of these investigations resulted from a change in the direction that the initiative has taken since the creation of the unbundling working group and implementation of the June 3rd guidance. In particular, Department attorneys and USAOs have proceeded with caution in unbundling investigations in order to ensure that errors made in the past are not repeated and do not mar ongoing investigations. Additionally, in many cases, hospitals have requested extensions of time to further review claims data or obtain additional information for analysis. Districts have readily agreed to requests for additional time by hospitals.

Now on pp. 11-14.

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In four of the five districts discussed, you indicate that hospitals were alleged to have violated the False Claims Act before knowledge of actual violations was obtained. It is true that one district sent contact letters discussing possible False Claims Act violations to certain hospitals prior to obtaining detailed claims data for those hospitals. However, these letters were sent before the June 3rd guidance, and this oversight has since been corrected. For all of the other districts cited, the districts invariably contacted hospitals only after having examined several years of claims data suggesting the submission of improper claims. Upon receiving letters from USAOs, hospitals were informed that certain claims had been identified that might constitute false claims and were given information regarding the areas of identified concern. Districts are still in the investigative stage of the laboratory unbundling initiative and the investigations are proceeding cooperatively. This cooperative approach to these investigations is consistent with the careful analysis of potential False Claims Act cases required by the June 3rd guidance.

Districts investigating unbundling cases have obtained varying degrees of evidence that false claims were submitted knowingly by hospitals. In a few instances, evidence of knowing unlawful conduct has been acquired through conventional means such as subpoenas or interviews. Other indicia of knowledge may have been obtained through detailed analysis of claims data. Generally, districts have taken a measured, cooperative approach to conducting unbundling investigations. The districts have attempted to work with hospitals to minimize the use of discovery tools -- such as subpoenas -- that are traditionally employed to determine the extent to which improper billings are knowingly submitted.

With respect to claims data audits being undertaken by the hospitals in the transition districts you visited, self-audits have always been, and remain, a voluntary option for hospitals. One district that is continuing to work with hospitals on voluntary self audits is mentioned in the report as lacking evidence that the hospitals' claims were false or that the False Claims Act was violated. In fact, however, the district raised the self-audit option only after acquiring evidence suggesting that improper claims were submitted. In the absence of evidence that the hospitals knew these claims to be false, this district followed the June 3rd guidance and chose not to pursue these matters under the False Claims Act. Rather, the district entered into settlement discussions with hospitals simply to enable the United States to be made whole from the improper payments that the hospitals received. The pending investigations are being examined on an individualized basis and, while the hospitals are pursuing self-audits, they are not being required to do so.

Finally, the Department recognizes the difficulties GAO encountered in conducting this review in light of the Department's longstanding policy of protecting the confidentiality and integrity of pending investigations. We greatly appreciate GAO's agreement to protect the confidential nature of documents reviewed by GAO auditors. As you know, the Department made every possible attempt to facilitate the GAO review. For example, we provided access to information sought by GAO regarding closed cases. We also facilitated discussions with supervisory USAO personnel in the districts GAO visited. In some instances, we were able to provide GAO access to redacted materials in pending cases because they already had been

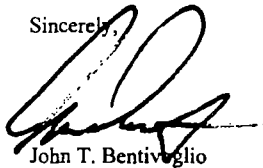
Appendix III
Comments From the Department of Justice

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provided to the hospitals. Unfortunately, pursuant to the Department's longstanding policy regarding pending matters – which is designed to protect the integrity of our law enforcement efforts – we could not provide complete access to some information sought by GAO.

Thank you very much for the opportunity to comment on this draft report. The Department remains committed to the fair and responsible use of the False Claims Act in civil health care matters.

Sincerely,



John T. Bentivoglio



HEALTH CARE FINANCING ADMINISTRATION

**ADDRESSEE:***Devorah***FROM:***Marva Mah*

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*Don't know if you
still need this -
Friend Fred Stet.*

man

HHS FACT SHEET

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

January 4, 1999

Contact: HHS Press Office
(202) 690-6343

A COMPREHENSIVE STRATEGY TO FIGHT HEALTH CARE FRAUD, WASTE AND ABUSE

Overview: Since 1993, the Clinton Administration has focused unprecedented attention on the fight against fraud, abuse and waste in the Medicare and Medicaid programs. Today, the result is a series of investigations, indictments and convictions, as well as new management tools to identify wasteful mispayments to health care providers.

The heightened focus on fraud and abuse since 1993 by the HHS Inspector General, the FBI and Department of Justice, HHS' Health Care Financing Administration (HCFA) and others throughout government is yielding a new, more detailed picture of fraudulent activities aimed at the Medicare and Medicaid systems. New surveys and audits have helped investigators pinpoint areas of vulnerability and ongoing patterns of abuse, which in turn are leading to changes in law enforcement and administrative actions. In addition, beneficiaries themselves are being trained to spot and report fraud and misspending.

At HHS, Secretary Shalala launched Operation Restore Trust, a ground-breaking project aimed at coordinating federal, state, local and private resources and targeting them on areas most plagued by abuse. During its two-year demonstration phase, the project identified \$23 in overpayments for every \$1 of project costs. In addition, the Secretary led the way toward steady, guaranteed funding for anti-fraud efforts by the HHS Inspector General, included in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Under the Health Care Fraud and Abuse Control Program, also created under HIPAA, HHS has reported more than \$1.2 billion in fines and restitution returned to the Medicare Trust Fund during fiscal years 1997 and 1998. During these years, HHS also excluded more than 5,700 individuals and entities from doing business with Medicare, Medicaid, and other federal and state health care programs for engaging in fraud or other professional misconduct -- up from 2,846 in the previous two years. In addition, HHS increased convictions by nearly 20 percent in 1997 and another 16 percent in 1998. Since 1993, actions affecting HHS health care programs have saved taxpayers more than \$35 billion, and have increased convictions and other successful legal actions by more than 240 percent.

In December 1998, President Clinton announced that his Year 2000 budget proposal will include an anti-fraud and abuse legislative package that would save Medicare another \$2 billion over 5 years by eliminating excessive Medicare payments for drugs, ensuring that Medicare doesn't pay for claims owed by Private Insurers, and other measures.

FIGHTING FRAUD, WASTE, AND ABUSE IN MEDICARE AND MEDICAID

Operation Restore Trust. In May 1995, President Clinton launched Operation Restore Trust (ORT), a comprehensive anti-fraud initiative in five key states designed to test the success of several innovations in fighting fraud and abuse in the Medicare and Medicaid programs. HCFA, the HHS Inspector General, and the HHS Administration on Aging are working in partnership to carry out ORT. During the two year demonstration, ORT identified \$23 in overpayments for every \$1 spent looking at suspected trouble spots in Medicare, including home health care, skilled nursing facilities, and providers of durable medical equipment. In May 1997, Secretary Shalala announced that with its successes demonstrated, ORT techniques would be expanded nationwide and applied to additional areas of fraud and abuse.

- **Fraud and Abuse Hotline.** HHS has expanded the 1-800-HHS-TIPS hotline started in 1995 to report fraud and abuse in Medicare and Medicaid programs. Some 32,000 complaints that warranted follow-up action have been received since it began service. Assistance is available in both English and Spanish.
- **Administration on Aging Ombudsman Program.** As a partner in Operation Restore Trust, the Administration on Aging has trained thousands of paid and volunteer long term care ombudsman and other aging services providers to recognize and report fraud and abuse, including problems in nursing homes and other long term care settings.

Guaranteed and Expanded Funding. In August 1996, President Clinton signed the Health Insurance Portability and Accountability Act (HIPAA) legislation into law, which for the first time created a stable source of funding for fraud control. This law established the Health Care Fraud and Abuse Control Account, a key proposal of the Clinton Administration, to which money is deposited annually from the Medicare Part A Trust Fund to help finance expanded fraud and abuse control activities. The additional funding began with \$104 million in FY 1997, and will total \$137.5 million in FY 1999, divided between HHS and the Department of Justice. The special funding is used to coordinate federal, state and local health care law enforcement programs, conduct investigations, provide guidance to the health care industry on fraudulent health care practices, and establish a national data bank to receive and report final adverse actions against unscrupulous health care providers and suppliers.

- **Expanded Office of the Inspector General (OIG).** Funding from the Health Care Fraud and Abuse Control Account has enabled the OIG to place personnel in an additional 12 states to carry out enforcement actions, increasing from 26 to 38 the number of states in which the OIG is present.
- **Increased Efforts by the Department of Justice (DOJ).** Funding from the Health Care Fraud and Abuse Control Account has also enabled the Department of Justice, including the FBI, to step up its efforts to investigate health care fraud. DOJ has increased resources, focused investigative strategies, and improved coordination among law enforcement agencies. The number of successful legal action against fraud and other crimes in the health care field has increased by more than 240 percent since FY 1992.

Rewards for Fraud and Abuse Information. The Incentive Program for Fraud and Abuse Information, which was also created under HIPAA, was implemented in July 1998. Under this program, rewards can be paid to Medicare beneficiaries and others who report fraud and abuse in the Medicare program. Their information must lead directly to the recovery of Medicare money for fraudulent activity, and the provisions can only apply for cases not already under investigation by federal or state

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agencies or Medicare's contractors. Rewards will be for 10 percent of the recovered overpayment or a \$1,000 maximum, and will be financed from the collected overpayments.

Tightening Standards for Home Health Care Providers. Because of extensive evidence of abuse, home health was one of the initial targets of Operations Restore Trust:

- In September 1997, HHS imposed a four-month moratorium on enrollment of new home health care providers in the Medicare program while new regulations were developed to keep unscrupulous and unqualified providers from entering the program. The new regulations included provisions requiring home health agencies to post surety bonds of at least \$50,000 before they can enroll or re-enroll in Medicare, requiring a minimum number of patients to establish an agency's experience prior to seeking Medicare enrollment, and requiring agencies to submit detailed information about all businesses they own to prevent the use of improper financial transactions. With the new regulations in place, the moratorium was lifted in January 1998.
- Medicare also has doubled the number of home health audits and increased claims review by 25 percent. It has also increased survey frequency for problem agencies and secured authority to exclude providers convicted of health care-related fraud, as well as establishing minimum capitalization requirements to ensure that new agencies have enough funds on hand to operate responsibly. HHS also now requires home health agencies to be more accountable for the care they provide, and to conduct criminal background checks on the aides they hire.
- HHS is also developing a new payment system for home health services that includes incentives to provide for care efficiently and avoid unnecessary visits. The new system will pay providers prospectively, similar to the way Medicare pays hospitals.

Savings from home health anti-fraud initiatives have been projected by the Congressional Budget Office at \$8.8 billion over five years, in addition to further savings to be realized from payment reforms.

New Requirements for Durable Medical Equipment Suppliers. Payment for durable medical equipment was another area targeted by Operation Restore Trust because of evidence of extensive abuse. In 1998, HHS proposed new regulations for suppliers of DME (including wheelchairs, canes, and other medical supplies), aimed at assuring that beneficiaries would be served by legitimate businesses. The new regulations would require suppliers to obtain surety bonds and would ban DME supplier telemarketing. It would also require suppliers to have a physical office and a listed phone number, and would codify a requirement that suppliers reenroll in Medicare every three years. In addition, it would prohibit suppliers from reassigning a supplier number, and would apply criminal and civil sanctions for misrepresentations on billing number applications. At the same time, Medicare began conducting on-site inspections of all medical equipment suppliers when they apply to participate in the program and when they re-enroll, to assure that beneficiaries are served by legitimate businesses.

Targeting fraud in Community Mental Health Centers. In September 1998, HHS announced new actions to ensure that Medicare beneficiaries with acute mental illness receive quality treatment in community mental health centers and that Medicare pays appropriately for those services. As part of a comprehensive action plan, HHS began termination actions against centers that were unable to provide Medicare's legally required core services, and required others to come quickly into compliance. HHS also demanded repayment of money that had been paid inappropriately for non-covered services or

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ineligible beneficiaries. The actions came after HCFA and the HHS Inspector General found providers enrolled in the program who were not qualified to deliver psychiatric services, as well as enrollment of patients who were ineligible for the Medicare benefit, and services billed to Medicare that were not appropriate. As part of Operation Restore Trust, HCFA had begun in 1997 to identify patterns of fraud and abuse of the benefit at community mental health centers. In 1998, HCFA followed up with site visits to about 700 Medicare-participating centers and applicants. Many met few, if any, of the statutory requirements for Medicare participation, raising doubts about their ability to care properly for beneficiaries.

The Medical Integrity Program (MIP) and Payment Safeguards. This system of payment safeguards, also authorized by HIPAA, identifies and investigates suspicious claims throughout Medicare, and ensures that Medicare does not pay claims other insurers should pay. MIP also ensures that Medicare only pays for covered services that are reasonable and medically necessary. HCFA's current payment safeguards are already paying dividends in cost savings. These safeguards comprise a comprehensive system which attempts to identify improper claims before they are paid, to prevent the need to "pay and chase." HCFA's current strategy for program integrity focuses on prevention and early detection. Some of the payment safeguard activities include the Medicare Secondary Payer Program, medical review, cost report audits and anti-fraud activities. The payment safeguard activities returned \$14 for every \$1 spent, and saved an estimated \$7.5 billion for FY 1997. The Secondary Payment Program alone, which is identifying whether insurers should pay claims that in the past have inappropriately been paid by Medicare, saved more than \$1.1 billion in 1997.

Improving Health Care Industry Compliance. The HHS Office of the Inspector General has issued compliance program guidance for hospitals to assist in developing measures to combat fraud and abuse in the hospital industry. In addition, the OIG released guidelines identifying steps for clinical laboratories, hospitals, home health agencies, and third-party billers to undertake to improve adherence to Medicare and Medicaid statutes, regulations, and program directives. The guidelines are part of the Inspector General's continuing efforts to work with health care providers to promote voluntary compliance with the applicable statutes, regulations, and program requirements pertaining to federal and other health care programs. In addition, the OIG has issued fraud alerts, advisory opinions and other guidance as part of an ongoing effort to promote the highest level of ethical and lawful conduct by the health care industry.

Correct Coding Initiative. In 1994, HCFA began the Correct Coding Initiative by awarding a contract for the development of correct coding policy for all physician billing codes referred to as current procedural terminology (CPT) codes. Implemented in 1996, this enhanced pre-payment, control and associated software update resulted in \$215 million in savings in FY 1997. So far, Medicare has developed more than 100,000 edits to detect improper claims. In addition, HCFA has begun using commercial off-the-shelf data processing products.

Substantive Claims Testing. HCFA is now working to develop a substantive testing process to help determine not only whether claims are paid properly, but also whether services are actually rendered and medically necessary.

Education Efforts. HCFA's contractors educate the provider billing community, including hospitals, physicians, home health agencies and laboratories about Medicare payment rules and fraudulent activity. This education covers current payment policy, documentation, requirements and coding changes through quarterly bulletins, fraud alerts, seminars and, more importantly, through local medical review policy.

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Tough New Requirements for Medicare and Medicaid Participants. President Clinton's FY 1998 budget proposal included several additional anti-fraud provisions. In addition, President Clinton introduced new legislation in March 1997, the "Medicare/Medicaid Anti-Waste, Fraud and Abuse Act of 1997," that established tough new requirements for individuals and companies that wish to participate in Medicare and Medicaid. Most of the Clinton Administration's recommendations were included in the budget bill signed by the President on August 5, 1997, including:

- Penalties for services billed by a provider who has been excluded by Medicare and Medicaid.
- Penalties for hospitals who contract with providers who have been excluded by Medicare and Medicaid.
- Civil monetary penalties levied on providers that violated the anti-kickback statute, under which the physician received some kind of incentive for referring patients.
- Requiring health care providers applying to participate in Medicare or Medicaid to provide their Social Security numbers and their employer identification numbers so HCFA can check an applicant's history for past fraudulent activity.
- Barring convicted felons from participating in Medicare and Medicaid.

Budget 2000 Anti-Fraud and Abuse Legislative Package. To build on unprecedented success in fighting health care fraud, waste, and abuse, President Clinton's FY 2000 budget proposal will include further anti-fraud and abuse legislative package that would save Medicare some \$2 billion over five years. The package includes measures that would eliminate current requirements in federal law which require Medicare to make excessive payments for certain drugs; prevent abuse of Medicare's "partial hospitalization" benefit; ensure that Medicare does not pay for claims owed by private insurers; expand HCFA contracting authority to purchase high-quality and cost-effective health care; and expanding HCFA's authority to terminate contractors who do not perform effectively.

Administration on Aging "Fraud Buster Projects." The Administration on Aging (AoA) has trained thousands of paid and volunteer long-term care ombudsman, insurance counselors and other aging service providers to recognize and report fraud and abuse in nursing homes and other service settings. The AoA also awarded \$2 million in grants to 12 states to recruit and train thousands of retired professionals to serve as health care "fraud busters" who works with older persons in their communities to review benefits statements and report potential cases of waste, fraud, and abuse. Millions of persons have been reached through the projects' public service announcements, community education events, train sessions, and informational materials.

###

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET

ROUTE SLIP

TO: <u>SACAH Rosen-Wartell</u>	Take necessary action	☐
<u>Chris Jennings</u>	Approval signature	☐
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Ron Jones

FROM: 395-3386

DATE: 4/6/99

REMARKS

Attached is a bankruptcy-related proposal from HHS. They would like to include it in the DOJ crime bill now in clearance.

Please let me know ^{4/7} if you object to this provision ASAP. (preferably prior to noon, Wednesday)

Thanks
Ron Jones

SEC. ____ . APPLICATION OF CERTAIN PROVISIONS OF THE BANKRUPTCY
CODE.

(a) RESTRICTED APPLICABILITY OF BANKRUPTCY STAY, DISCHARGE,
AND PREFERENTIAL TRANSFER PROVISIONS TO MEDICARE AND MEDICAID
DEBTS.—Title XI of the Social Security Act is amended by
inserting after section 1143 the following new section:

"APPLICATION OF CERTAIN PROVISIONS OF
THE BANKRUPTCY CODE

"Sec. 1144. (a) MEDICARE AND MEDICAID-RELATED ACTIONS NOT
STAYED BY BANKRUPTCY PROCEEDINGS.—The commencement or
continuation of any action against a debtor under this title or
title XVIII or XIX (other than an action with respect to health
care services for the debtor under title XVIII), including any
action or proceeding to exclude or suspend the debtor from
program participation, assess civil money penalties, recoup or
set off overpayments, or deny or suspend payment of claims shall
not be subject to the provisions of section 362(a) of title 11 of
the United States Code.

"(b) MEDICARE- AND MEDICAID-RELATED DEBT NOT DISCHARGEABLE
IN BANKRUPTCY.—A debt owed to the United States or to a State
for an overpayment under title XVIII or XIX (other than an
overpayment for health care services for the debtor under title
XVIII), or for a penalty, fine, or assessment under this title or
title XVIII or XIX, shall not be dischargeable under any
provision of title 11 of the United States Code.

"(c) REPAYMENT OF CERTAIN DEBTS CONSIDERED FINAL.—Payments
made to repay a debt to the United States or to a State with

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respect to items or services provided, or claims for payment made, under title XVIII or XIX (including repayment of an overpayment (other than an overpayment for health care services for the debtor under such title XVIII)), or to pay a penalty, fine, or assessment under this title or title XVIII or XIX, shall be considered final and not preferential transfers under section 547 of title 11 of the United States Code."

(b) MEDICARE RULES APPLICABLE TO BANKRUPTCY

PROCEEDINGS.—Title XVIII of the Social Security Act is amended by adding at the end the following new section:

"APPLICATION OF PROVISIONS OF THE BANKRUPTCY CODE

"Sec. 1897. (a) USE OF MEDICARE STANDARDS AND PROCEDURES.—Notwithstanding any provision of title 11 of the United States Code or any other provision of law, in the case of claims by a debtor in bankruptcy for payment under this title, the determination of whether the claim is allowable, and of the amount payable, shall be made in accordance with the provisions of this title and title XI and implementing regulations.

"(b) NOTICE TO CREDITOR OF BANKRUPTCY PETITIONER.—In the case of a debt owed to the United States with respect to items or services provided, or claims for payment made, under this title (including a debt arising from an overpayment or a penalty, fine, or assessment under title XI or this title), the notices to the creditor of bankruptcy petitions, proceedings, and relief required under title 11 of the United States Code (including under section 342 of that title and section 2002(j) of the

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Federal Rules of Bankruptcy Procedure) shall be given to the Secretary. Provision of such notice to a fiscal agent of the Secretary shall not be considered to satisfy this requirement.

"(c) **TURNOVER OF PROPERTY TO THE BANKRUPTCY ESTATE.**—For purposes of section 542(b) of title 11 of the United States Code, a claim for payment under this title shall not be considered to be a matured debt payable to the estate of a debtor until such claim has been allowed by the Secretary in accordance with procedures under this title."

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET

ROUTE SLIP

TO: <u>SACAH Rosen-Wartell</u>	Take necessary action	☐
<u>Chris Jennings</u>	Approval signature	☐
<u>Sarah Besinaki</u>	Comment	☐
<u>Devonish Adler</u>	Prepare reply	☐
<u>Leanne Lamborn</u>	Discuss with me	☐
	For your information	☐
	See remarks below	☐

Ron Jones

FROM: 395-3386

DATE: 4/6/99

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