The Department of Health and Human Services
And
The Department of Justice
Health Care Fraud and Abuse Control Program
Annual Report For FY 2002

SEPTEMBER 2003

TABLE OF CONTENTS

	Page
Executive Summary	1
Introduction	3
Monetary Results	5
Program Accomplishments	7
Department of Health and Human Services	15
Office of Inspector General	15
Office of the General Counsel	21
Administration on Aging	23
Centers for Medicare and Medicaid Services	24
Assistant Secretary for Budget, Technology and Finance	25
Department of Justice	27
United States Attorneys	27
Civil Division	32
Criminal Division	33
Civil Rights Division	35
Justice Management Division	37
Appendix: Federal Bureau of Investigation - Mandatory Funding	39
Glossary of Terms	41

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

EXECUTIVE SUMMARY

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a national Health Care Fraud and Abuse Control Program (HCFAC or the Program), under the joint direction of the Attorney General and the Secretary of the Department of Health and Human Services (HHS)[1], acting through the Department's Inspector General (HHS/OIG), designed to coordinate Federal, state and local law enforcement activities with respect to health care fraud and abuse. In its sixth year of operation, the Program's continued success again confirmed the soundness of a collaborative approach to identify and prosecute the most egregious instances of health care fraud, to prevent future fraud or abuse, and to protect program beneficiaries.

Monetary Results

In 2002, the Federal government won or negotiated more than $1.8 billion in judgments, settlements, and administrative impositions in health care fraud cases and proceedings. As a result of these activities, as well as prior year judgments, settlements, and administrative impositions, the Federal government collected over $1.6 billion, of which approximately $1.4 billion was returned to the Medicare Trust Fund. An additional $59 million was recovered as the federal share of Medicaid restitution. This is the largest return to the government since the inception of the Program**.**

Enforcement Actions

Federal prosecutors filed 361 criminal indictments in health care fraud cases in 2002. A total of 480 defendants were convicted for health care fraud-related crimes during the year. There were also 1,529 civil matters pending, and 221 civil cases filed in 2002. HHS excluded 3,448 individuals and entities from participating in the Medicare and Medicaid programs, or other federally sponsored health care programs, most as a result of convictions for crimes relating to Medicare or Medicaid, for patient abuse or neglect, or as a result of licensure revocations.

[1]Hereafter, referred to as the Secretary.

INTRODUCTION

ANNUAL REPORT OF
THE ATTORNEY GENERAL AND THE SECRETARY
DETAILING EXPENDITURES AND REVENUES
UNDER THE HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM
FOR FISCAL YEAR 2002

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

STATUTORY BACKGROUND

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

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

As stated above, the Act appropriates monies from the Medicare Trust Fund to an expenditure account, called the Health Care Fraud and Abuse Control Account (the Account), in amounts that the Secretary and Attorney General jointly certify as necessary to finance anti-fraud activities. The maximum amounts available for certification are specified in the Act. Certain of these sums are to be used only for activities of HHS/OIG, with respect to Medicare and Medicaid programs. In 2002, the Secretary and the Attorney General certified $209 million for appropriation to the Account. A detailed breakdown of the allocation of these funds is set forth later in this report. These resources generally supplement the direct appropriations of HHS and the Department of Justice (DOJ) that are devoted to health care fraud enforcement, though they provide the sole source of funding for Medicare and Medicaid enforcement by HHS/OIG. (Separately, the Federal Bureau of Investigation (FBI) received $101 million from HIPAA which is discussed in the Appendix.)

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

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

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

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

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

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

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

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

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

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

This annual report fulfills the above statutory requirements.

MONETARY RESULTS

As required by the Act, HHS and DOJ must detail in this Annual Report the amounts deposited and appropriated to the Medicare Trust Fund, and the source of such deposits. In 2002, as a result of the combined anti-fraud actions of the Federal and state governments and others, the Federal government collected a record high of more than $1.6 billion in connection with health care fraud cases and matters.[3] These funds were deposited with the Department of the Treasury and the Centers for Medicare and Medicaid Services (CMS), transferred to other Federal agencies administering health care programs, or paid to private persons. The following chart provides a breakdown of the transfers/deposits:

Total Transfers/Deposits by Recipient 2002	
Department of the Treasury	
HIPAA Deposits to the Medicare Trust Fund	
Gifts and Bequests	$ 6,820
Amount Equal to Criminal Fines	430,536,063
Civil Monetary Penalties	6,692,976
Amount Equal to Asset Forfeiture *	0
Amount Equal to Penalties and Multiple Damages	328,566,049
Centers for Medicare and Medicaid Services	
OIG Audit Disallowances - Recovered	150,239,823
Restitution/Compensatory Damages	551,205,138
Restitution/Compensatory Damages to Federal Agencies	
Office of Personnel Management	50,571,353
Other Agencies	12,536,742
Relators' Payments **	101,165,649
TOTAL ***	**1,631,520,613**

*This includes only forfeitures under 18 U.S.C. § 1347, a Federal health care fraud offense that became effective on August 21, 1996. Not included are forfeitures obtained in numerous health care fraud cases prosecuted under Federal mail and wire fraud and other offenses.
**These are funds awarded to private persons who file suits on behalf of the Federal government under the *qui tam* provisions of the False Claims Act, 31 U.S.C. § 3730(b).
***Funds are also collected on behalf of state Medicaid programs and private insurance companies; these funds are not represented here.

The above transfers include certain collections, or amounts equal to certain collections, required

[3]In 2002, DOJ collected, or continued to hold in suspension, additional funds from health care fraud cases and matters that were not disbursed to the affected agencies and/or the Account in 2002 due to: (i) ongoing litigation regarding relator shares in *qui tam* cases that will affect the amount retained by the Federal government; and (ii) receipt of funds late in the year that were then processed in FY 2003.

by HIPAA to be deposited directly into the Medicare Trust Fund. These amounts include:

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

(2) Criminal fines recovered in cases involving a Federal health care offense, including collections under section 24(a) of title 18, United States Code (relating to health care fraud);

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

(4) Amounts resulting from the forfeiture of property by reason of a Federal health care offense, including collections under section 982(a)(6) of title 18, United States Code; and

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

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

PROGRAM ACCOMPLISHMENTS

EXPENDITURES

In the sixth year of operation, the Secretary and the Attorney General certified $209 million as necessary for the Program. The following chart gives the allocation by recipient:

2002 ALLOCATION OF HCFAC APPROPRIATION (Dollars in thousands)	
Organization	**Allocation**
Department of Health and Human Services	
Office of Inspector General[4]	145,000
Office of the General Counsel	4,180
Administration on Aging	2,000
Centers for Medicare and Medicaid Services	2,675
Assistant Secretary for Budget, Technology and Finance	125
Total	153,980
Department of Justice	
United States Attorneys	25,200
Civil Division	26,029
Criminal Division	1,270
Civil Rights Division	1,815
Justice Management Division	886
Total	55,200
Total	**$209,180**

[4]In addition, HHS/OIG obligated $ 2,059,000 in funds received as "reimbursement for the costs of conducting investigations and audits and for monitoring compliance plans" as authorized by section 1128C(b) of the Social Security Act, 42 U.S.C. § 1320a-7c(b).

ACCOMPLISHMENTS

Collections

During this year, the Federal government won or negotiated more than $1.8 billion in judgments, settlements, and administrative impositions in health care fraud cases and proceedings. As a result of these activities, as well as prior year judgments, settlements, and administrative impositions, the Federal government collected $1.6 billion in cases resulting from health care fraud and abuse, of which approximately $1.4 billion was returned to the Medicare Trust Fund, and $59 million was recovered as the Federal share of Medicaid restitution. It should be emphasized that some of the judgments, settlements, and administrative impositions in 2002 will result in collections in future years, just as some of the collections in 2002 are attributable to actions from prior years.

Judgments/Settlements

Working together, HHS, DOJ and their partners have brought to successful conclusion the investigation and prosecution of numerous health care fraud schemes. Among them are:

- **TAP Pharmaceutical Products Inc. (TAP),** a major pharmaceutical manufacturer, agreed to pay $875,000,000 to resolve criminal charges and civil liabilities in connection with its fraudulent pricing and marketing of the cancer drug, Lupron. Under the global agreement, TAP agreed to plead guilty to a conspiracy to violate the Prescription Drug Marketing Act and to pay a $290,000,000 criminal fine. To resolve its civil liability under the FCA, TAP agreed to pay the United States $559,483,560 for filing fraudulent claims with Medicare and Medicaid, and to pay the fifty states and the District of Columbia $25,516,440 for filing fraudulent claims with the states. Additionally, TAP entered a sweeping corporate integrity agreement which significantly changes the manner in which TAP supervises its marketing and sales staffs, and ensures that TAP will report to the Medicare and Medicaid programs the true average sale price for drugs reimbursed by those programs.

  While Medicare does not pay for most drugs, Medicare does cover those, such as Lupron, that must be injected under the supervision of a physician. Medicare paid for 80 percent of either the urologist's charge for Lupron or the average wholesale price (AWP) reported by TAP, whichever was lower. The government alleged that TAP set and controlled the price at which the Medicare program reimbursed physicians for the prescription of Lupron by misreporting its AWP as significantly higher than the average sales price TAP offered physicians and other customers for the drug. TAP allegedly “marketed the spread” between its discounted prices paid by physicians and the significantly higher Medicare reimbursement based on AWP as an inducement to physicians to obtain their Lupron business. The government further alleged that TAP concealed the true discounted prices paid by physicians from Medicare, and falsely advised physicians to report the higher AWP rather than their real discounted price for the drug.

The investigation, prosecution and settlement reflect a collaborative effort among the United States Attorneys Office Massachusetts, the DOJ, the FBI, the HHS/OIG, the Food and Drug Administration (FDA) Office of Criminal Investigations and the Department of Defense, Defense Criminal Investigation Service (DCIS).

- **Federal Employees Health Benefits**. PacifiCare Health Systems agreed to pay the United States $87.3 million to settle allegations that it and its predecessor companies violated the FCA with respect to claims submitted to the Office of Personnel Management (OPM). This represents the largest civil settlement involving the Federal Employees Health Benefits Program (FEHBP). Based on an investigation by the OPM Office of Inspector General, the government alleged that PacifiCare's subsidiaries failed to follow applicable rules when developing the rates it charged for health care benefits under its FEHBP contracts, including failing to give the health care program the same discounted rates the company gave its similarly situated commercial customers, failing to coordinate FEHBP benefits with those provided to Medicare eligible annuitants; and submitting statements to OPM that failed to fully disclose rate adjustments due to FEHBP.

- **Medicaid Eligibility.** The State of California and the County of Los Angeles agreed to pay $73.3 million to resolve their civil liability under the FCA and Civil Monetary Penalties Law for submitting claims for services provided to minors who were not Medicaid eligible. The settlement resolves allegations that the State and the County billed the Federal health care program for services provided to minors when these jurisdictions had no basis for concluding that these individuals financially qualified for Medicaid services. The services at issue in this matter involve treatment for drug and alcohol abuse, pregnancy and pregnancy related services, family planning, sexual assault treatment, sexually transmitted diseases and mental health services.

- **Medicare contractor cases:**

  - General American Life Insurance Company, Inc. (General American) agreed to pay $76 million to settle allegations of misconduct occurring when the company served as a Medicare Part B carrier. General American allegedly failed to process claims properly, then submitted false information to CMS regarding the accuracy of and the timeliness with which it handled those claims. The company also allegedly breached its contract by failing to report errors identified in the quality assurance process; and concealing its true error rate by deleting claims selected for review by CMS and replacing them with claim files that would not significantly affect their error rate (and so preserve their standing within carrier performance rankings). Additionally, General American allegedly hid documents, altered others and falsified numerous reports. No corporate integrity agreement was entered since General American has ceased to be a carrier.

    In a separate proceeding, General American's former Medicare Director was sentenced to 27 months in prison for conspiracy to falsify and conceal information

from Federal auditors.

- Florida Medical Quality Assurance, Inc. (FMQAI) and its parent company, Alabama Quality Assurance Foundation (AQAF) agreed to pay $838,832 to resolve allegations that FMQAI submitted false claims for reimbursement to Medicare. The two firms are peer review organizations that perform services under direct contracts with the CMS. The settlement resulted from a government investigation following a self-disclosure that revealed the improper charging to FMQAI's Medicare contract of time and expenses actually spent on FMQAI's Medicaid contract with a state agency in Florida. A *qui tam* complaint was also filed in the case.

- **Ambulance Services.** American Medical Response, Inc. (AMR), the nation's largest ambulance service provider, agreed to pay $20 million to resolve its civil and administrative liability for false claims submitted to Medicare. The *qui tam* action involved allegations that AMR's Massachusetts subsidiary and certain of its predecessor companies had billed for medically unnecessary services, falsified certificates of medical necessity and engaged in other improper billing practices. As part of the settlement, AMR entered into a 3-year corporate integrity agreement with HHS/OIG.

- **Hospital Contractor**. KPMG, LLP (KPMG, formerly KPMG Peat Marwick, LLP), agreed to pay $9 million, plus interest, to the Federal government to resolve allegations of submitting false hospital cost reports to the Medicare and Medicaid programs on behalf of clients Basic American Medical, Inc. and Columbia Hospital Corporation. The government alleged that KPMG knowingly made claims that were false, exaggerated or ineligible for payment, and concealed errors from government auditors, thereby permitting the client hospitals to retain funds to which they were not entitled. KPMG also prepared "reserve" cost reports detailing non-allowable expenses and allocations contained in the filed cost reports and estimated the reimbursement impact in the event that these non-allowable expenses and allocations were detected on audit.

These and other settlements reflect the culmination of investigations that have been ongoing for several years.

Quality of Care

One area in which collaboration has proved most effective has been in enforcement and oversight of issues relating to quality of care, as demonstrated by the following:

Enforcement Actions. Several important enforcement actions culminated in 2002:

- In Missouri, as the result of a joint investigation by the FBI and the FDA, a pharmacist diluted drugs that had been prescribed as treatment for cancer patients. He pleaded guilty to 8 counts of consumer product tampering, 6 counts of drug adulteration, and 6 counts of drug misbranding, and was sentenced to a term of 30 years imprisonment. The 30 year

prison term represented an upward departure from the guideline sentencing range and was the maximum sentence available under the plea agreement. The pharmacist and his corporation also were ordered to pay a fine of $25,000 and victim restitution of $10.5 million, which will be distributed using assets seized during the government's civil prosecution.

On the civil side, the Court entered a consent decree banning the pharmacist until further order of the Court from practicing pharmacy, possessing pharmacy licenses, or violating any provision of the Food, Drug, & Cosmetic Act. The assets previously frozen in the civil case were transferred to the criminal case for use as restitution by victims. The pharmacist confessed to diluting in excess of 60 different drugs beginning in 1992 until his arrest in August of 2001. All of the drugs that may have been diluted were administered intravenously or through injection. The pharmacist's actions affected approximately 400 physicians, 4,200 patients, and 98,000 prescriptions.

- A California physician and clinic owner/operator was convicted of multiple felony counts, including mail fraud, wire fraud, bankruptcy fraud and making false statements. The physician deliberately misdiagnosed patients as suffering from a rare vascular disease that requires patients to obtain expensive pumps, braces and other medical devices. The physician was also convicted of making false statements when he filed for bankruptcy in 1996. The physician was sentenced to 5 years in prison and ordered to pay $2.87 million in restitution.

- An Indiana man was sentenced to 21 months in prison and ordered to pay $1.9 million in restitution to persons who suffered injury as a result of his role in a conspiracy to defraud insurance carriers and cancer patients. The man worked as the business manager for a practitioner and operator of a medical center. The two aggressively marketed treatments not approved by FDA to terminally ill cancer patients. The individual falsely billed these treatments as if the patients received chemotherapy, and created and submitted false documents to insurance companies to support the billings.

- As the result of a joint investigation by HHS/OIG and the Maryland Medicaid Fraud Control Unit (MFCU), a registered nurse and owner of a dialysis clinic was sentenced to 5 years in jail, with all but 18 months suspended, and ordered to pay $100,000 in restitution for Medicaid fraud and reckless endangerment. In addition, his clinic was fined $300,000 for Medicaid fraud. For more than two years, the nurse failed to administer epogen, a synthetic hormone typically administered during dialysis, and falsified epogen administration flow sheets.

Nursing Facility Quality of Care – OIG Symposium. The HHS/OIG hosted a symposium entitled, "Nursing Facility Quality of Care: Improving Government Enforcement Efforts." The symposium sought to enhance the government's enforcement efforts through an analysis of the current methods utilized by the government to pursue quality of care cases in nursing homes. The symposium included a series of case studies presented by attorneys and investigators who had successfully conducted quality of care cases. The meeting drew participants from CMS, DOJ,

United States Attorneys' Offices (USAOs), MFCUs, state survey officials, and the HHS/OIG.
Recommendations to Improve Quality of Care. The HHS/OIG issued several significant reports assessing a variety of facets of the quality of care provided to program beneficiaries. These included:

- **Psychotropic Drug Use in Nursing Homes.** In response to concerns expressed by the Senate Special Committee on Aging, HHS/OIG conducted an evaluation on the use of psychotropic drugs as inappropriate chemical restraints in nursing homes. The study found that this is not a pervasive problem. Where there are problems, they are related to inappropriate dosage, chronic use, a lack of documented benefit to the resident, and unnecessary duplicate drug therapy. The report also noted a lack of adequate documentation for residents' psychotropic drug use in some cases. The HHS/OIG recommended that CMS consider educating providers to better document the use of these drugs.

- **Oversight of Ambulatory Surgery Centers (ASCs).** An OIG inspection assessed how and how well State agencies and accreditors oversee ASCs, and how CMS holds them accountable. ASCs have experienced explosive growth, more than doubling in number from 1990 to 2000. During the same time period, the volume and complexity of procedures performed in ASCs have increased dramatically, from 12,000 to over 101,000 major procedures annually. For these reasons, oversight is more important than ever, but Medicare's system of quality oversight is flawed. Nearly one-third of ASCs have not been recertified for 5 or more years, and CMS has done little to monitor the performance of State agencies and accreditors. The report made recommendations to CMS to strengthen its quality oversight of ASCs. CMS responded positively, but did not fully commit itself to some recommendations, particularly those calling for a minimum survey cycle and a more accessible complaint process.

- **Physician's Role in Medicare Home Health 2001.** The HHS/OIG released a final inspection report on the physician's role in Medicare home health. Based on interviews with physicians and review of CMS claims data, this study found that physicians are currently playing a key role in initiating, certifying, and monitoring the care for Medicare home health beneficiaries. However, they feel they have limited knowledge of Medicare home health rules and CMS' expectations of them. At present, the availability of reimbursement for their oversight role does not seem to have significant impact on physicians who care for Medicare home health patients. In order to address physician concerns and improve the Medicare home health services, HHS/OIG recommended that CMS establish a working group of their Physician Regulations Issues Team to improve communication and to consider modifying the physician home health oversight role.

Pharmaceuticals

Enforcement Actions: Prescription drug pricing remains an important area of inquiry for the HCFAC program. A number of investigations, audits and evaluations focused on whether the government is paying reasonable and appropriate amounts for covered prescription drugs. For example:

- In Florida, Eckerd Corporation agreed to pay the government $5.9 million and to enter into a 5-year corporate integrity agreement to resolve the corporation's liability for submitting claims for partially filled prescriptions. A *qui tam* alleged that between 1986 and 2000, the chain pharmacy submitted false claims each time it dispensed only a portion of a prescription to beneficiaries, but billed Medicaid, TRICARE and the Federal Employee Health Benefits Program (FEHBP) for the full amount of the prescription.

- In Maine, the twenty-first person was sentenced for his role in leading a large-scale OxyContin distribution ring. The man was sentenced to 21 years and 10 months in prison and ordered to pay $6,000 in restitution for health care fraud, conspiracy to acquire controlled substances by fraud, and conspiracy to distribute and possess with intent to distribute controlled substances. In a related Federal case, he was also sentenced to life in prison after being found guilty in a separate jury trial for distribution of a controlled substance resulting in death.

Studies of Medicare and Medicaid Drug Pricing and Payment:

- **Medicaid Payments for Prescription Drugs**: The HHS/OIG found that Medicaid could save significant dollars in reimbursements to pharmacies for brand name and generic prescription drugs. Most states use AWP, minus a percentage discount, as a basis for reimbursing pharmacies for drug prescriptions. In 1999, this discount averaged about 10 percent nationally, which HHS/OIG believes is not sufficient to ensure that reasonable prices are paid. Based on pricing information from pharmacies in eight states, HHS/OIG estimated that the nationwide actual acquisition cost averaged about 22 percent for brand name and 66 percent for generic below AWP. HHS/OIG estimated that the Medicaid program could have saved as much as $1.6 billion in 1999 for the top 200 brand and generic drugs if reimbursements had been made suing the lower averages. This savings calculation was limited to ingredient acquisition costs and did not address other costs, such as dispensing fees.

Hospitals

Improperly Reported and Paid Discharges: Under Medicare rules, a consolidation of hospitals is considered a change of ownership. After a consolidation, only the surviving hospital would be entitled to Medicare payments because it was the legal owner on the date patients were discharged. The HHS/OIG conducted a review to determine whether hospitals that ceased to exist after consolidation with another hospital improperly submitted claims for prospective

payment system discharges. The review revealed that 15 such hospitals were improperly paid $8 million for 1,118 prospective payment system discharges. These claims were submitted and paid because neither the fiscal intermediaries nor the hospitals had a clear understanding of Medicare payment rules on hospital consolidations. The DOJ has reached settlements, and fiscal intermediaries have begun collecting the overpayments.

Disproportionate Share Hospital Payments: The Medicare, Medicaid, and State Child Health Insurance Program Benefits Improvement and Protection Act of 2000 increased public hospitals' Medicaid disproportionate share hospital (DSH) reimbursement from 100 percent to 175 percent of uncompensated care costs—a change expected to increase Federal spending by $380 million during FYs 2003 through 2005. Based on recent and ongoing reviews, HHS/OIG has concluded that the reimbursement increase may not be warranted. These studies have shown that DSH payments are not always retained by public hospitals, are often returned to the states for other uses, and are not always calculated correctly. The HHS/OIG recommended that CMS seek legislation to at least delay, if not repeal, the implementation of the increase in DSH payments until the need for and use of DSH funds for direct care of uninsured patients can be examined. If the new limit is implemented, additional legislative reform is needed to ensure that DSH funds remain at the hospitals to provide care to vulnerable populations. CMS initially concurred, but later said that it would not seek a legislative change.

Reviews during 2002 found that DSH payments to some hospitals in California and Missouri exceeded the individual hospitals' uncompensated costs, contrary to provisions of the Omnibus Budget Reconciliation Act of 1993. DSH payments to one hospital exceeded its hospital-specific limit by $38.7 million. In both states, the limits were overstated because the states' calculations were flawed. The HHS/OIG recommended that the states return the overpayments to the Federal government and implement procedures and controls to prevent similar claims.

A more detailed description of these and other accomplishments of the major Federal participants in the coordinated effort established under HIPAA follows. While information in this report is presented in the context of a single agency, most of these accomplishments reflect the combined efforts of HHS, DOJ and other partners in the anti-fraud efforts.

FUNDING FOR DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General

Certain of the funds appropriated under HIPAA are, by law, set aside for Medicare and Medicaid activities of HHS/OIG. During the sixth year of the Program, the Act provided that between $140 and $150 million be devoted to these purposes. The Secretary and the Attorney General jointly allotted $145 million to HHS/OIG in 2002, an increase of $15 million over 2001.

HHS/OIG conducted or participated in 753 prosecutions or settlements in 2002, of which 568, or 75 percent, were health care cases. A total of 3,448 individuals and entities were also excluded, many as a result of criminal convictions for crimes related to Medicare or Medicaid (670); or to other health care programs (138); for patient abuse or neglect (296); or as a result of licensure revocations (1,720).

In addition to HHS/OIG's role in bringing about the judgments and settlements described in the Overview of Accomplishments, HHS acted on HHS/OIG recommendations and collected $150.2 million in disallowances of improperly paid health care funds in 2002. HHS/OIG continues to work with CMS to develop and implement recommendations to correct systemic vulnerabilities detected during HHS/OIG evaluations and audits. These corrective actions often result in health care funds not expended (that is, funds put to better use as a result of implemented HHS/OIG initiatives). In 2002, such funds not expended amounted to more than $19.8 billion -- nearly $14.3 billion in Medicare savings, and $5.6 billion in savings to the Medicaid program.

Fraud and Abuse Prevention

HIPAA's increased resources have enabled HHS/OIG to broaden its efforts both to detect fraud and abuse, and to prevent it. Prevention initiatives, such as those listed below, inform and assist the health care industry and its patients. Equally important, these prevention activities reduce program losses and enforcement costs.

- **Industry Guidance:** The centerpiece of the HIPAA guidance initiatives is an advisory opinion process through which parties may obtain binding legal guidance as to whether their existing or proposed health care business transactions run afoul of the Federal anti-kickback statute, the civil monetary penalties laws, or the exclusion provisions. During 2002, HHS/OIG issued 20 opinions. A total of 86 advisory opinions have been issued since 1997. The advisory opinion process serves to enhance HHS/OIG's understanding of new and emerging health care business arrangements, and informs the development of new safe harbor regulations, fraud alerts, and special advisory bulletins.

- **Corporate Integrity Agreements, and the Inspector General's Open Letter:** Many health care providers that enter agreements with the government in settlement of potential liability for violations of the FCA also agree to adhere to a separate corporate integrity agreement (CIA). Under this agreement, the provider commits to establishing a program or taking other specified steps to ensure its future compliance with Medicare and Medicaid rules. These agreements require a substantial effort by the provider to ensure that the organization is operating in accordance with Federal health care program requirements and the parameters established by the CIA. At the close of 2002, HHS/OIG was monitoring more than 325 CIAs.

  On November 20, 2001, the Inspector General issued an "Open Letter to Health Care Providers" in which she announced modifications to CIAs in response to concerns expressed by the provider and enforcement community. The full text of the letter can be found on the Internet at http://oig.hhs.gov .

- **Medicare Error Rate:** The HHS/OIG estimated that improper Medicare benefit payments made during 2001 totaled $12.1 billion, or about 6.3 percent of the $191.8 billion in processed fee-for-service payments reported by CMS. These improper payments, as in past years, reflect a range of conduct, from reimbursement for services provided but inadequately documented, to inadvertent mistakes, to outright fraud and abuse.

  The 2001 estimate of improper payments is almost half the $23.2 billion that was first estimated for 1996. As a rate of error, the current 6.3 percent estimate is the lowest to date, less than half the 13.8 percent reported for 1996. However, HHS/OIG advised CMS to continue its efforts to ensure that providers maintain adequate documentation supporting billed services, bill only for services that are medically necessary, and properly code claims.

- **Recommendations for Systemic Improvements:** Frequently, investigations, audits and evaluations reveal vulnerabilities or incentives for questionable or fraudulent financial practices in agency programs or administrative processes. As required by the Inspector General Act, HHS/OIG makes recommendations to address these vulnerabilities, and thereby promotes economy and efficiency in HHS programs and operations. Relying on the independent factual information generated by HHS/OIG, agency managers recommend legislative proposals or other corrective actions that, when enacted or implemented, close loopholes and reduce improper payments or conduct. The net savings from these joint efforts toward program improvements can be substantial. Many of the studies described throughout this report offered evidence and ideas supporting proposals for significant cost savings during 2002 and beyond. Examples of these reviews include the following:

  - **Capped Rental Equipment**: Medicare Part B pays for certain pieces of durable medical equipment such as hospital beds, nebulizers, and wheelchairs under the capped rental category. After a certain period of time, beneficiaries are given the

option to purchase the equipment. If they opt to do so, Medicare will pay for repairs to the equipment. If the beneficiary continues to rent, Medicare will pay a semiannual sum to cover maintenance and servicing of the equipment; a fee that is paid regardless of whether such services are actually provided. The HHS/OIG tracked payments for more than 3,500 pieces of durable medical equipment that were purchased or leased in 1996. This 5-year analysis disclosed that Medicare paid substantially more for maintenance on rented equipment than it did for repairs on purchased equipment. Furthermore, an analysis of supplier documentation found only 9 percent of the capped rental equipment actually received any maintenance and servicing. For these reasons, the OIG recommended that CMS eliminate the semiannual maintenance payment for rental equipment and, instead, pay only for repairs when needed. This would result in approximately $100 million being saved each year by Medicare and its beneficiaries. The CMS agreed with the recommendations and will consider a legislative initiative to eliminate the rental option altogether.

- **Delinquent Medicare Debt:** Despite CMS' significant progress in managing debt, especially at Medicare contractors, serious problems remain. The HHS/OIG identified an estimated $670 million (absolute value) in misstated and misclassified delinquent Medicare debt in information reported to the Treasury Department. Misstatements included $450 million in reconciliation errors, $68 million in unsupported or unrecorded transactions, and $152 million in classification errors regarding the debt's eligibility for referral to Treasury for collection. Also, CMS did not have an adequate process for pursuing debt using the required demand letters. The CMS agreed with HHS/OIG recommendations for improving supporting documentation, periodic reconciliations, and supervisory review of delinquent debt activities.

- **Incorrectly Reported Hospital Transfers:** Reviews continued to find significant problems with hospital reporting of inpatient prospective payment system (PPS) transfers as discharges. Since 1992, the number of incorrectly reported transfers has trended downward but remains high. The HHS/OIG identified over 153,000 claims for incorrectly reported transfers from January 1992 through June 2000 with potential overpayments totaling nearly $233 million. Contributing causes include misapplication of the PPS transfer policy by CMS regional offices and fiscal intermediaries, problems with computer system interfaces at hospitals, and breakdowns in communication between hospitals' medical and billing staffs. The HHS/OIG recommended, among other things, that CMS clarify instructions on the PPS transfer policy and initiate collection of the overpayments identified to date. The CMS agreed to collect overpayments for the 4-year period specified in regulations regarding the reopening of Medicare claims.

  Another review found that Medicare paid 1,610 hospitals an additional $6.8 million because the hospitals reported patients as having left against medical advice (called LAMA discharges), when, in actuality, the patients were admitted to another hospital on the same day. This problem occurred primarily because

LAMA discharges were not included in the computerized system edits designed to detect same-day discharge and admission to another hospital. CMS generally concurred with recommendations to recover overpayments and develop adequate internal controls and monitoring safeguards to detect and address transfers reported as LAMA discharges.

- **Deported Beneficiaries:** At the request of the Senate Finance Committee, HHS/OIG examined Medicare payments made on behalf of deported beneficiaries. Of an identified 1,072 deported Medicare beneficiaries, 49 had improper payments totaling $837,000 made on their behalf during 1998 and 1999. These payments occurred because CMS did not include deportation information in its main database of Medicare enrollment data for processing payments to fee-for-service or managed care providers. In addition to recommending financial adjustments, HHS/OIG recommended that CMS use the deportation information already in its possession to preclude such improper payments. The CMS generally concurred.

- **Nail Debridement Services:** An HHS/OIG evaluation found that Medicare paid approximately $97 million for inappropriate nail debridement and related services during calendar year 2000. Almost one-fourth (22.7 percent) of the sampled claims did not have adequate medical justification to support Medicare payment. This represented approximately $51.2 million in Medicare payments. In addition, the study showed that more than half (60 percent) of the inappropriately paid nail debridement claims also contained related podiatry services. When a nail debridement payment is determined to be inappropriate, the other podiatry payments for services related to the nail debridement are also inappropriate. Medicare paid $45.6 million for such related services. CMS agreed to require carriers to closely scrutinize payment for nail debridement services through medical reviews and require podiatrists to adequately document the medical need for all nail debridements.

- **Program Exclusions:** The HHS/OIG excluded 3,448 individuals and entities from participation in Medicare, Medicaid and other Federal health care programs. Such exclusions are a vital way to prevent continued fraud and to protect program beneficiaries. Exclusions included:

  - A Missouri transportation company owner/operator was excluded for 15 years after he was convicted of submitting or causing the submission of false claims for ambulance services provided to patients. Additionally, he entered into a $325,000 settlement agreement in a parallel civil suit.

  - In Colorado, two certified nurse aides (CNAs) were convicted in a time-card fraud scheme that lasted more than a year and resulted in a loss to Medicaid of approximately $63,000. Additionally, one of the CNAs had previously been convicted and had violated his parole. Both were excluded for 10 years.

Focus on Quality of Care

HHS/OIG investigations, audits and evaluations focus not just on improper billing for health care services, but also the quality of care provided to program beneficiaries. Activities designed to promote or safeguard beneficiary care included:

- **Enforcement Actions:**

  - National HealthCare Corporation (NHC) and related entities agreed to pay the government $250,000 to resolve a FCA and administrative actions involving quality of care problems. NHC is a publicly traded nationwide nursing home chain with a number of facilities in Missouri, including Joplin. The case stemmed from a complaint survey performed by the Missouri Division of Aging in 1998. The survey cited the Joplin facility for failure to prevent pressure sores, prevent accidents and maintain proper nutrition; these issues were primarily attributed to Joplin's failure to maintain a proper staffing level. As part of the settlement, NHC also agreed to a comprehensive corporate integrity agreement for Joplin.

  - In Louisiana, Twin Oaks Nursing Home, Inc. (Twin Oaks), agreed to pay the government $100,000 to resolve allegations of failing to provide appropriate care. Issues included deficiencies in documentation, improper staffing levels, inadequate supplies and deteriorated equipment. Twin Oaks also agreed to enter into a 5-year corporate integrity agreement that includes a quality monitor requirement.

  - A licensed practical nurse at a Pennsylvania nursing home was sentenced to 10 months incarceration and lost her nursing license for falsifying a patient's record after a medication error was discovered. The error was a contributing factor in the patient's later death.

Other Judgments and Settlements.

In addition to the significant enforcement actions described in the Program Accomplishments section of this report, and those immediately above, HHS/OIG conducted or participated in numerous investigations that resulted in prosecution or settlement during 2002, involving all aspects of the health care industry. These include**:**

- **Kickbacks**: The Balanced Budget Act of 1997 authorized the HHS/OIG to impose civil monetary penalties against those who pay or receive remuneration in violation of the anti-kickback statute. During 2002, the HHS/OIG stepped up enforcement efforts under this administrative authority. Among these actions were:

  - A Tennessee investigation revealed a scheme in which a mobile ultrasound company paid referral fees to physicians, ostensibly in the form of rent, to induce the physicians to refer Medicare beneficiaries for diagnostic testing. The ultrasound company and its owners agreed to pay $225,000 to resolve their civil

monetary penalty liability for violations of the anti-kickback statute and the physician self-referral (Stark) law. Under the settlement agreement, the company ceased operations, one owner agreed to a permanent exclusion from participation in Federal health care programs, and the other owner agreed to certify to HHS/OIG concerning her employment and compensation over the next five years. In separate actions, HHS/OIG entered settlement agreements with a physician group and individual physicians for the payment of a total of $117,900 to resolve their civil monetary penalty liability for this arrangement.

- A Georgia corporation that provides home infusion services self-disclosed a kickback arrangement involving one of its subsidiaries. The operator of that subsidiary paid illegal fees to a nurse at a local hospital in exchange for the nurse's referring Medicare and Medicaid patients to the subsidiary's home infusion facility. The operator paid the nurse a fixed percent of collected net revenues for referred patients, and disguised those referral fees as sales commissions. When headquarters discovered the kickback arrangement, the operator was terminated, and the location closed. The U.S. Attorney's Office declined to pursue the case under the civil FCA because it determined that the HHS/OIG's civil monetary penalty authority was a more appropriate remedy in this kickback case. The company agreed to pay $130,691 and to implement certain measures to supplement its current compliance program.

- Allina Health System, a large integrated health care organization operating a variety of medically-related facilities and businesses, agreed to pay more than $16 million to settle allegations that it submitted false claims to the Medicare, Medicaid and TRICARE programs. The government alleged that Allina's hospitals and clinics violated the FCA by knowingly seeking reimbursement through a variety of improper billing methods, such as duplicate billing and upcoding. The settlement also resolves *qui tam* claims that Allina knowingly retained overpayments after the company's own audits demonstrated that it had submitted erroneous claims. As part of the settlement, Allina agreed to enter into a comprehensive 5-year corporate integrity agreement covering all of its lines of business.

- In one of the longest sentences ever imposed in a Federal health care case, a Texas woman was sentenced to 17.5 years in jail and ordered to pay over $9.3 million in restitution and over $3,000 in special assessments after being convicted on 32 counts of health care fraud. The woman defrauded Medicare, Medicaid and several private insurance companies by billing for services not rendered through multiple clinics she established (some of which were entirely fictitious). The false claims included inpatient hospital visits, physical therapy and chemotherapy. Although first indicted on 17 counts of health care fraud in April 2000, the woman continued her false billings and as a result, was indicted on 15 additional counts of health care fraud in May 2001.

Evidence showed that the woman, even after two indictments, still continued to falsely bill health care programs for services not rendered.

- Molina Healthcare of California, Inc., doing business as Molina Medical Centers (Molina), a Medicaid managed care plan in California, paid $600,000 to resolve its civil monetary penalty liability for furnishing false and misleading information to Medicaid beneficiaries. Molina sent over 17,000 letters to its Medicaid enrollees stating that if these beneficiaries did not re-enroll with Molina they would lose access to their primary care physicians. Further, these letters appeared as though they were sent directly from the beneficiaries' physicians; in reality, they were sent by a mailing house at the direction of Molina.

- In Florida, four individuals were sentenced to an average length of imprisonment of 11 years and ordered jointly to pay a total of $11.7 million in restitution for conspiracy, fraud and money laundering. The four conspired to defraud Medicare and Medicaid by submitting false claims for laboratory tests. To carry out their scheme, the group used confidential Medicare and Medicaid information to prepare laboratory test requisitions for tests not actually performed. Using the requisitions to support the corresponding Medicare and Medicaid claims, the four fraudulently obtained payments from the programs.

Office of the General Counsel

The Office of the General Counsel (OGC) was allocated $4.18 million in HCFAC funding for 2002 to supplement OGC's efforts to support the Administration's program integrity activities. These funds were used primarily for litigation activity, both administrative and judicial.

Accomplishments:

Suspensions

- OGC provided legal advice and review to CMS for more than 90 suspension actions. Based on reliable evidence of fraud, CMS suspended payments involving over $50 million to a Florida medical laboratory. Plaintiff filed a Federal court action that was dismissed and then pursued its administrative remedies, while DOJ initiated a fraud investigation.

Litigation

- In nursing home enforcement, OGC opened 310 new administrative cases before the Departmental Appeals Board (DAB) in 2002. Civil Monetary Penalties (CMPs) against nursing homes totaled $10.893 million resulting from favorable DAB decisions and negotiated settlements. Before the Sixth Circuit Court of Appeals OGC briefed and argued a case in a nursing home's appeal of a DAB decision upholding all deficiencies and a $365,000 CMP.

- DOJ sued a supplier of special mattresses for wound care, seeking to recover $1 million in

overpayments on the theories of fraud, unjust enrichment, and mistake of fact. OGC provided litigation support and programmatic advice to DOJ as the Medicare overpayment case proceeded to trial.

Bankruptcies

- OGC continues to be heavily involved with CMS's bankruptcy workload. OGC protects Medicare funds by asserting CMS's recoupment rights to collect overpayments, by arguing to continue suspension or termination actions against debtors or by seeking adequate assurances from the bankruptcy court that CMS's interests in the debtor's estate will be protected, by arguing for the assumption of the Medicare provider agreement as an executory contract, and by petitioning for administrative costs where appropriate.

- "First Ruling" in Holyoke Nursing Home v. HCFA, the Bankruptcy Court for the District of Massachusetts followed the view of the 9th Circuit (In re TLC Hosp. Inc.) in holding that Medicare's overpayment recoveries effectuated through payment withholding constituted permissible recoupment (i.e. were neither avoidable preferential transfers prior to filing nor unauthorized offsets in violation of the automatic stay after filing).

- "First Ruling" in In re Maxicare Health Services, Inc. The district court judge recognized that Medicare payments are part of a single ongoing transaction between a provider and the Program and, as such, are subject to recoupment.

Policy Guidance and Education

- OGC worked with CMS Central Office on implementing web-based surveyor training, and recommended revisions to the case studies used in long term care surveyors' training. OGC attorneys also provided training directly, making presentations to approximately 175 California surveyors on surveying, documenting, and defending legally sufficient deficiencies, and instructing on legal aspects of surveying, documentation, and effective witness skills through "Basic Long Term Care Surveyor Training" to over 100 surveyors from several states.

- OGC established "practice groups" which identify national issues requiring policy clarifications and the most effective and efficient means of litigating long term care enforcement cases before the DAB.

- OGC provided legal guidance and assistance in drafting regulations involving: home health agencies, provider enrollment, coordination of benefits, and statistical analysis.

Administration on Aging

In 2002, the Administration on Aging (AoA) was allocated $2 million in HCFAC funds to develop and disseminate consumer education information to older Americans, with a particular focus on persons with low health literacy, individuals from culturally diverse backgrounds, persons living in rural areas, and other vulnerable populations. AoA and its nationwide network of agencies supported community education activities designed to assist older Americans and their families to recognize and report potential errors or fraudulent situations in the Medicare and Medicaid programs.

Accomplishments:

- National Technical Assistance Resource Centers: AoA continued to support four national resource centers that provide materials and technical assistance to professionals who serve older Americans in their communities. The purpose of the resource centers is to educate and empower vulnerable and culturally diverse older Americans and their families to take a more active role in monitoring and protecting the benefit integrity of the Medicare and Medicaid programs;

- National Health Care Fraud and Abuse Control Program Conference: AoA convened a national conference in Washington, D.C., which brought together more than 250 Federal, state, and community partners who are working to protect the benefit integrity of the Medicare and Medicaid programs. The purpose of the conference was to share successful products and practices, strengthen collaboration between Federal, state and local partners, and to work to advance the performance of the complaint referral process, outcome tracking mechanisms, and honor outstanding senior volunteers;

- Senior Medicare Patrol Projects: AoA provided technical assistance to AoA's 51 Senior Medicare Patrol (SMP) projects, located in 45 states plus the District of Columbia and Puerto Rico. The purpose of these projects is to recruit and train retired individuals to educate seniors in their communities about how they can help prevent and detect potential Medicare and Medicaid error, fraud, and abuse. In 2002, the projects trained 9,000 senior volunteers who directly educated 485,000 Medicare beneficiaries in their communities on topics such as how to read their Medicare summary notices;

- Development of Senior Medicare Patrol Website: AoA maintained a website dedicated to providing information about Medicare and Medicaid error, fraud, and abuse targeted to older Americans and community-based professionals who serve aging adults and their families. The site promotes consumer awareness and facilitates the sharing of information and best practices between Medicare and Medicaid beneficiaries, and AoA's grantees and partners. The website also links seniors to information about how to become a volunteer;

- Community Education Materials: HCFAC funding also supported the design and distribution of health care journals and community education videos in English, Spanish,

and Mandarin Chinese. A particular emphasis was made to target this information to AoA's nationwide network of aging service professionals;

- Community Education Activities: More than an estimated 5 million individuals were reached through a variety of television, radio, and print media events. While it is not possible to directly track all of the cases reported and dollars recovered through these community education activities, these projects reported nearly $15 million in Medicare, Medicaid, and other health insurance dollars recouped over the last six months of 2002;

Centers for Medicare and Medicaid Services

In 2002, $2.675 million in HCFAC funds was allocated to the CMS to provide Federal grant funding for states to participate in the second year of the Medicaid Payment Accuracy Measurement (PAM) project, which develops payment accuracy measurement methodologies and conducts pilot studies to measure and reduce state Medicaid payment errors.

Each of the twelve states will pilot test the CMS PAM Model. This model was developed by CMS and The Lewin Group, in collaboration with the nine states that participated during the first year of the project. The CMS PAM Model was designed to explore the feasibility of conducting payment accuracy studies in all states using a single methodology that can produce both state-specific and national level payment accuracy estimates. In addition, the CMS PAM Model has been designed to estimate payment accuracy for both the fee for service and managed care components of the Medicaid program. Of the twelve states, seven states will pilot test the model in fee-for-service, one state will pilot test the model in managed care, and four states will pilot test the model in both fee for service and managed care.

All states were solicited to participate in the PAM demonstration project under the authority of section 402(a)(1)(j) of the Social Security Act Amendments of 1967.

Accomplishments

- In response to the May 2002 all-state solicitation, CMS received applications from twelve states to participate in the PAM project; all twelve states were awarded grants in September 2002. The twelve states are: Florida, Indiana, Louisiana, Mississippi, Nebraska, New York, North Carolina, North Dakota, Oklahoma, Texas, Washington, and Wyoming. Notably, eight of these twelve states (Louisiana, Mississippi, New York, North Carolina, North Dakota, Texas, Washington and Wyoming) also participated in the first year of the project.

- CMS and The Lewin Group will be providing technical assistance to the twelve states during the second year of the project to ensure uniform implementation of the CMS PAM Model. Del Marva, a subcontractor to The Lewin Group, will be preparing medical review guidelines and conducting a quality assurance study of the error determination processes in each state to ensure consistency.

- The Lewin Group will also be conducting an analysis of the major factors influencing project costs to assist CMS in projecting the future costs of nationwide PAM project implementation.

Assistant Secretary for Budget, Technology and Finance

For 2002, $125,000 of funds from the Account were transferred to the Office of the Budget, Technology, and Finance to support the Unified Financial Management System (UFMS) Program. The overall strategic goal of the program is to unify HHS' financial management by designing and implementing a modern, Department-wide financial management system. Once fully implemented, UFMS will significantly enhance the Department's internal controls, management's stewardship, and accountability over financial transactions, operations, and assets. The unified system will be comprised of two primary sub-components–a system for CMS and its Medicare contractors (the Healthcare Integrated General Ledger and Accounting System (HIGLAS)) and another system for the rest of HHS. UFMS will also institute a consolidated departmental financial reporting capability. HHS will ensure the new system's compliance with statutory requirements of the Chief Financial Officers Act of 1990, the Federal Financial Management Improvement Act of 1996, the Reports Consolidation Act of 2000, the Federal Manager's Financial Integrity Act (FMFIA) of 1982, and other pertinent laws.

FUNDING FOR DEPARTMENT OF JUSTICE

United States Attorneys

Health care fraud involves a variety of schemes that defraud public insurers, private insurers and health care providers nationwide. In addition to Medicare and Medicaid, a number of federally funded health benefit programs have been the targets of health care fraud schemes. The fraudulent activity may include double billing schemes, kickbacks, billing for unnecessary or unperformed tests, or fraudulent activity may relate to the quality of care provided to patients. In addition to monetary losses, some improper activities endanger patient safety. United States Attorneys' offices (USAOs) are responsible for civil and criminal prosecutions of health care professionals, providers and others.

USAOs continue to strengthen and refine cooperative efforts with Federal, state and local law enforcement agencies involved in the prevention, evaluation, detection, and investigation of health care fraud and abuse. In addition to the FBI, HHS/OIG and CMS, USAOs work with State MFCUs, State Attorneys General, Offices of Inspectors General for a number of federal agencies, Drug Enforcement Administration (DEA), FDA, DCIS and TRICARE Support Office.

Each USAO has appointed both a civil and a criminal health care fraud coordinator to assist in tracking referrals, overseeing investigations and facilitating communication between Federal, state and local law enforcement groups. In addition, many cases are investigated in a parallel fashion, so that the potential criminal and civil remedies are addressed more efficiently, by the attorneys and agencies investigating the wrongdoing. The criminal and civil judgments and settlements discussed in the Program Accomplishments sections of this report provide examples of some significant health care cases in the USAOs, many of which are investigated as parallel investigations and prosecutions.

Prior to enactment of the HIPAA, USAOs dedicated substantial resources to combating health care fraud and abuse. HIPAA allocations have supplemented those resources by providing dedicated positions for attorneys, paralegals, auditors and investigators.

Training

The Executive Office for the United States Attorneys'/Office of Legal Education (OLE) is responsible for providing health care fraud training for Assistant United States Attorneys (AUSAs) and Department attorneys, paralegals, investigators, and auditors. During 2002, OLE conducted a number of courses and presentations on health care fraud, including:

- Health Care Fraud Symposium - Criminal AUSAs, Civil AUSAs and FBI Agents.
- Financial Investigations in Health Care Fraud - Health Care Fraud Paralegals, Investigators and Auditors in USAOs (two week course)
- Affirmative Civil Enforcement (ACE) Issues - Civil AUSAs

- ACE for Auditors and Investigators - HCF Auditors and Investigators (3 day course)
- Special Topics in Health Care Fraud - Criminal and Civil AUSAs

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

Program Accomplishments - Criminal Prosecutions

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

Each time a criminal case is accepted for consideration of prosecution in a USAO, it is opened as a matter pending in the district. A referral remains a matter until an indictment or information is filed or the case is declined for prosecution. In 2002, the USAOs had 1,606 health care criminal matters pending, involving 2,441 defendants.

During 2002, 361 cases were filed involving 608 defendants, a one percent increase over 2001 in the number of defendants. There were 480 health care related convictions in 2002, a three percent increase over 2001. Convictions include both guilty pleas and jury verdicts. A sample of the criminal cases brought by USAOs, in addition to those set forth in the overview section of this report, is set out below:

- In Alabama, defendants using an Internet website sold prescription drugs, including Viagra, Xenical, Celebrex, Propecia, and Claritin-D, to consumers who did not have valid prescriptions written by a licensed medical practitioner. As part of the scheme, they collected fees for non-existent medical consultations, repackaged drugs obtained from a pharmacy and a drug wholesaler (who was not authorized to provide drugs in Alabama) and shipped the drugs to customers in the United States and around the world. One defendant was sentenced to 188 months and another defendant was sentenced to 78 months imprisonment. They agreed to forfeit $370,000 in assets that had been frozen when the case was indicted. A third defendant, the drug wholesaler and president of the pharmaceutical supply corporation, entered a guilty plea. He was placed on probation for one year, ordered to perform 150 hours of community service, and pay a $1,500 fine. The corporation was ordered to pay a $125,000 fine.

- In Colorado, a chiropractor was convicted by a jury of submitting false Medicare claims for a controversial medical procedure known as chelation therapy. Chelation therapy is a recognized treatment only to reverse the effects of poisoning with heavy metals (such as lead). The treatment is carried out through the administration of an intravenous solution containing a
man-made amino acid known as EDTA (ethylene diamine tetra-acetic acid). The defendant operated a clinic which catered to heart disease patients, promising the patients

that chelation therapy would reverse or prevent heart disease, hardening of the arteries, diabetes and other generalized vascular conditions. The use of EDTA chelation therapy to treat such conditions is considered experimental and unproven, and Medicare has denied coverage for such treatments since 1982. The chiropractor obtained payments from Medicare by misrepresenting who provided the services, what the services were, and why the patients were being treated. He was sentenced to six years incarceration and restitution to Medicare of $118,000.

- In Kansas, a physician specializing in ear, nose and throat illnesses, performed unnecessary surgeries; billed for services not rendered; billed for more expensive procedures than were actually provided (upcoding); lured patients into unnecessary surgeries that caused them serious bodily injury; and created false documents as well as provided false testimony to cover up his fraud. In 1999, the government's expert witness found that 40 percent of 105 of the defendant's sinus surgeries were unnecessary; and that from 1998-99, all but one of the 40 mastoid ear surgeries the physician performed was unnecessary. Further, the defendant could not have performed the billed surgeries in the extremely short surgery times recorded. He was sentenced to 6 years in jail. No restitution or fine was ordered. The physician lost his license, and agreed to be excluded from Federal health care programs for 15 years after release from prison. Restitution was covered by the civil medical malpractice suits filed by the victims.

- In Maine, an investigation of an ambulance service revealed a variety of billing irregularities, including: claims to Medicare for ambulance transportation for patients actually transported in wheelchair vans; claims for more miles than were actually traveled; claims for advanced life support that was never provided; and claims for ambulance transports to hospitals, which is reimbursable, when in fact the patients were transported to doctors' offices, which is not reimbursable. The investigation also revealed altered or false documentation to Medicare and Medicaid auditors during administrative audits. The owner of an ambulance service was sentenced to 49 months in prison for money laundering, obstructing a federal audit, and violating Medicare and Medicaid laws. The fraud totaled $891,492. The ambulance service was placed on probation for 5 years. The defendants were ordered to pay $729,875 in restitution. A civil agreement with the United States and the State of Maine was negotiated for additional civil penalties of $300,000. As part of that agreement, the defendants were barred from doing business with Medicare, Medicaid, and other federal programs for 15 years.

- In New York, a plastic surgeon was charged with this scheme: (1) an employee of the defendant, who had no medical license and was not acting under a physician's supervision, performed procedures such as lesion removals and cosmetic vein injections, which were billed as though they had been performed by a licensed physician; (2) the defendant's clinic billed cosmetic procedures, such as tummy-tucks and liposuctions, as medically necessary procedures, such as hernia and lesion removals, in order to obtain insurance coverage; (3) the clinic submitted claims to insurance companies for procedures that were never performed; and (4) the clinic exaggerated insurance claims by increasing the number and complexity of procedures actually performed. At sentencing the judge found that the defendant intended to cause approximately $2.5 million in losses to 18

private insurance companies. The judge imposed an upward departure from the sentencing guidelines range, finding that the defendant's obstruction of justice was "widespread and diverse," and included tampering with witnesses, attempting to get other witnesses to lie, falsifying the clinic's medical records, destroying the clinic's records, submitting a false affidavit to the court in connection with a bail hearing and committing "wholesale perjury at trial." The defendant was sentenced to 11 years, 3 months in prison and ordered to pay $918,000 in restitution to the insurance company victims.

- In Texas, a physician electronically filed medical claim forms for 150 -180 allergy tests he claimed to have performed when, in fact, he did not have sufficient allergens to perform that number of tests. Also, he prepared phony progress notes regarding the false allergy tests in case Medicaid or Medicare requested supporting documentation when reviewing the claims. The allergy tests were painful and subjected the patient to possible severe reactions, such as abnormal heart rhythms, shortness of breath, severe rashes, swelling, and even death. The doctor had his staff randomly select 13 to 15 patient files per week and create "phantom" billings for dates on which he neither saw nor treated the patients whose insurance he billed. He instructed his staff to create false test results and false documentation, including progress notes, in order to conceal from Medicaid investigators and auditors his fraudulent billing activity and he submitted claims totaling more than $1.3 million to Medicaid for reimbursement on these "phantom" billings. The physician was sentenced to serve five years in prison following a guilty plea to health care fraud and money laundering charges. In addition, he agreed to pay $4 million to the government insurance programs he defrauded, including Medicare, Medicaid, and the FEHBP.

Program Accomplishments - Civil Cases

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

Each time a civil referral is made to a USAO it is opened as a matter pending in the district. Civil health care fraud matters are referred directly from federal or state investigative agencies, or result from filings by private persons known as "relators," who file suits on behalf of the Federal Government under the 1986 *qui tam* amendments to the FCA. Relators may be entitled to share in the recoveries resulting from these lawsuits. At the end of 2002, the USAOs had 1,529 civil health care fraud matters pending. A matter becomes a case when the United States files a civil complaint, or intervenes in a *qui tam* action, in United States District Court. The vast majority of civil health care fraud cases and matters are settled without a complaint ever being filed. In 2002, 221 civil health care fraud cases were filed.
A sample of the civil cases brought by USAOs, in addition to those in described in the overview section, are set forth below.

- In California, a health care company and its affiliate agreed to pay $8.5 million to settle

allegations that they and 13 of their hospitals knowingly defrauded Medicare and other federal health insurance programs by submitting fraudulent cost reports in order to obtain millions of dollars for costs which were inflated or not allowable. The Government alleged that the defendants kept two sets of books - those shown to the government's auditors and a second "reserve" or "booked" set hidden from the government which identified the unallowable and inflated costs included in the filed cost reports - and that the defendants set aside funds to repay the government in case the unallowable costs were eventually discovered. The United States' complaint also alleged fraudulent submissions made to the Medicaid and TRICARE/CHAMPUS programs.

- In the Northern District of Florida, companion *qui tam* lawsuits were filed alleging improper billings by physicians at a university. Allegations included false billings for diagnostic tests performed with inadequately calibrated equipment, inadequate resident supervision, lab consultations and optical procedures. The university entered into settlement in excess of $8 million.

- In the Southern District of Florida, three home health agencies were found to have submitted a wide range of false claims, including claims for treatment not medically necessary, not rendered, or rendered by unqualified personnel. Many inappropriate costs were included in their cost reports as well. This case subsequently settled for $29 million.

- In Minnesota, a corporation agreed to pay more than $6.1 million to settle allegations under the FCA concerning a range of issues relating to its Medicare claims for durable medical equipment, primarily parenteral and enteral nutrition products and supplies. Two whistle-blower suits alleged that false claims resulted in Medicare overpayments from 1988 to 1997, as the result of submitting claims on behalf of patients for whom the company lacked certificates of medical necessity. The relators also charged that the corporation routinely waived the beneficiary's portion of the cost of certain goods; accepted and retained payments exceeding the maximum Medicare allowance for the product or supply; and submitted claims for urological supplies to the wrong Medicare contractor for processing, resulting in overpayment.

- In New York, a *qui tam* action was filed alleging that a wound care company caused its hospital partners to include unallowable marketing and advertising costs on the costs reports submitted to Medicare for reimbursement. The wound care company agreed to pay $16.5 million in settlement of the suit.

Civil Division

Civil Division attorneys vigorously pursue civil remedies in health care fraud matters, working

closely with the USAOs, the FBI, the Inspectors General of the HHS and the Department of Defense, CMS, and other federal and state law enforcement agencies. Cases involve providers of health care services, supplies and equipment, as well as carriers and fiscal intermediaries, that defraud Medicare, Medicaid, TRICARE, the FEHBP, and other government health care programs.

Accomplishments

In 2002, the Division opened or filed a total of 74 health care fraud cases or matters. In addition to these new efforts, the Civil Division pursued 390 existing cases. A significant number of these health care fraud cases have the potential for particularly high damages. Civil Division attorneys were actively involved in the recoveries described in the overview – TAP Pharmaceuticals, PacifiCare Health Systems, General American Life Insurance, the State of California, American Medical Response, and the KPMG cases. The following examples demonstrate the breadth and significance of other cases in which the Division was involved during 2002.

- Schering-Plough Corporation agreed to pay $500 million to resolve allegations that the company did not manufacture drugs in compliance with FDA regulations – for example, the company manufactured asthma inhalers without the correct amount of medicine inside. The injunction allows Schering to manufacture noncompliant products that FDA believes are necessary to the public health, but requires Schering to disgorge the profits obtained from the sale of those noncompliant products. Schering also must make additional payments if it fails to bring these medically necessary products into full compliance with FDA regulations in a timely fashion.

- Lifemark Hospitals of Florida, a subsidiary of Tenet Healthcare Corporation paid $29 million for allegedly submitting false Medicare claims for services provided by three home health agencies. In another settlement, Tenet paid $17 million to resolve allegations that 139 of its hospitals overcharged multiple, federally insured health care programs for laboratory services.

- In the Mariner Post-Acute Network bankruptcy, the court approved a settlement in which Mariner, which operates nursing homes in 25 states, will pay $26 million to resolve civil fraud liability. Additionally, Mariner will forfeit its interest in $29 million to resolve Medicare overpayment liabilities.

In addition to these case-specific accomplishments, the Department's Nursing Home Initiative, coordinated by the Civil Division, promotes, among other things, increased prosecution and coordination at Federal, state and local levels to fight the abuse, neglect, and financial exploitation of the nation's senior and infirm population. The Department is pursuing a growing number of cases under the FCA involving providers' egregious "failures of care." The financial crisis in the nursing home industry has to date resulted in bankruptcy filings by five of the seven largest nursing home chains and several smaller chains. These bankruptcy cases are the largest ever involving health care providers, and raise the specter of failure of care, as well as financial issues. The significance of these cases require considerable and ongoing coordination among the

Civil Division's Corporate Finance and Civil Fraud sections, the Criminal Division, CMS, and HHS/OIG. In addition, as part of the Nursing Home Initiative, the Department, through the Office of Justice Programs, has made several grants to further knowledge of the forensic aspects of elder abuse, to promote prevention, and to assist local prosecutors in elder abuse, neglect, and exploitation matters.

Also, the Civil Division co-chairs with the Criminal Division the National Level Health Care Fraud Working Group, which meets quarterly and coordinates the health care fraud enforcement activities of all concerned Federal and state agencies.

Vital resources were made available from the Account to provide the Civil Division with personnel, Automated Litigation Support, auditors, and consultants. These resources supplemented other Civil Division funds. During 2002, these monies were used to support a host of health care fraud matters and the Department's tobacco litigation.

Criminal Division

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

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

- coordinating large scale multi-district health care fraud investigations;
- providing frequent advice and written materials on confidentiality and disclosure issues arising in the course of investigations and legal proceedings regarding medical records;
- monitoring and coordinating Departmental responses to major regulatory initiatives, legislative proposals, and enforcement policy matters. Examples include issues such as provider education and regulation, medical records privacy, Internet sales of drugs and medical products and expansion of the Medicare program to provide prescription drug benefits;
- reviewing and commenting on numerous requests for advisory opinions submitted by health care providers to the HHS/OIG, and consulting with the HHS/OIG on draft advisory opinions per the requirements of HIPAA;

- working with CMS officials to promote more effective use of technologies and high-tech approaches for combating health care fraud and abuse. Examples include co-sponsoring with CMS two regional conferences and working with several USAOs to coordinate with CMS during its transition to Program Safeguard Contractors for conducting anti-fraud detection work in the Medicare program;

- preparing and distributing to all USAOs and FBI field offices periodic updates on major issues, interagency initiatives, and significant activities of DOJ's health care fraud component organizations as well as periodic summaries of recent cases;

- organizing and overseeing, in conjunction with the Civil Division, the National Level Health Care Fraud Working Group to address fraud in health care and managed care;

- participating in interagency working groups formed to address illicit Internet sales of drugs and medical products and nursing home fraud and resident abuse;

The Fraud Section has responsibility for handling complex health care fraud litigation nationwide and examples of successful prosecutions in 2002 include:

- HCMF Corporation, a privately owned nursing home chain in Virginia, which was entitled under the Medicare and Medicaid programs to claim reimbursement for the administrative costs associated with its operation of eighteen nursing homes throughout Virginia, pleaded guilty to improperly claiming reimbursement for salaries and benefits paid to more than thirty HCMF owners, family members and employees who performed little or no functions for nursing homes or whose duties were largely unrelated to operating the homes. As part of its plea agreement, HCMF agreed to pay restitution to these programs in the amount of $1.7 million, was sentenced to one year probation and ordered to pay a $275,000 fine. Additionally, HCMF agreed to pay $250,000 of the costs of prosecution. Both the Chairman of HCMF's Board of Directors and the Treasurer of HCMF pleaded guilty to making false statements in connection with a Federal health care program, and concealing information from Medicare and Medicaid so that HCMF could continue receiving reimbursement. The Chairman was held jointly and severally liable for the restitution amount, was sentenced to 30 months probation, and ordered to pay a fine of $10,000. The Treasurer was sentenced to 24 months of probation, with 50 hours of community service, and ordered to pay a $2,500 fine. In addition, these two officers, by virtue of their guilty pleas, will be excluded from the health care benefit programs for at least five years.

- Two physicians, two licensed pharmacists, and four pharmacy and durable medical equipment (DME) owners were convicted in the largest Medicare fraud conspiracy trial in the Southern District of Florida. As part of the conspiracy, the defendants paid patients for their Medicare cards and for signing blank delivery receipts without receiving any medication. The physician defendants issued fraudulent prescriptions to the patients, ordered unnecessary tests, medical equipment and medication, and thereafter the DME defendants forwarded the prescriptions to co-conspirator pharmacies and submitted false

bills to Medicare in excess of $15 million for medication and medical equipment that was never delivered. Additionally, the pharmacist and pharmacy owner defendants, who were unwilling to buy expensive medications approved by the FDA in the volumes necessary to fill prescriptions, manufactured unnecessary, non-FDA approved medications through a process called "compounding," and provided the DME companies with documentation reflecting full deliveries of FDA-approved medications even though "compounded" medications were supplied and often times only half or none of the medication was actually delivered to the DME companies. Following a 5 ½ month trial, a jury convicted the eight defendants of conspiracy to defraud the United States and additionally convicted one defendant of filing false claims, paying kickbacks, and conspiracy to commit money laundering; a second defendant of paying kickbacks; and a third defendant of filing false claims and paying kickbacks. Eighteen co-defendants entered guilty pleas prior to trial.

Civil Rights Division

The Special Litigation Section of the Civil Rights Division vigorously pursues relief affecting public, residential health care facilities and has established an Institutional Health Care Abuse and Neglect Initiative to carry out the Department's initiative to eliminate abuse and grossly substandard care in Medicare and Medicaid funded nursing homes and other long-term care facilities.

The Section plays a critical role in the HCFAC Program and is the sole Department component responsible for the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997 (CRIPA). CRIPA authorizes investigation of conditions of confinement at state and local residential institutions (including facilities for persons with developmental disabilities or mental illness, and nursing homes) and initiation of civil action for injunctive relief to remedy a pattern or practice of violations of the constitution or federal statutory rights. The review of conditions in facilities for the mentally ill and for persons with developmental disabilities, and nursing homes comprises a significant portion of the program. The Special Litigation Section works collaboratively with the USAOs around the country and with HHS.

Accomplishments

As part of the Department's Institutional Health Care Abuse and Neglect Initiative, and as an enhancement to the Department's ongoing CRIPA enforcement efforts, the Special Litigation Section staff reviewed conditions and services at 60 nursing home facilities in 24 states during 2002. The task in preliminary inquiries is to determine whether there is sufficient information supporting allegations of unlawful conditions to warrant formal investigation under CRIPA.

The section reviews information pertaining to areas such as abuse and neglect, medical and mental health care, use of restraints, fire and environmental safety, and placement in the most integrated setting appropriate to individual needs.

In 2002, the Special Litigation Section opened full CRIPA investigations of four nursing homes:

Mercer County Nursing Home in Trenton, New Jersey; Nim Henson Geriatric Center in Breathitt County, Kentucky; Reginald P. White Nursing Facility in Meridian, Mississippi; and Claudette Box Nursing Facility in Mt. Vernon, Alabama. The Section resolved its CRIPA investigation of the Long Term Care Division of the Bergen Regional Medical Center in Paramus, New Jersey through a memorandum of understanding that provides for improved medical care, accident and fall prevention, reduced use of restraints and an assessment of whether the residents are being served in the most integrated setting appropriate to their needs.

Staff participated in ongoing nursing home investigations, including the investigation of Laguna Honda Hospital in San Francisco, California, the largest public nursing home facility in the United States; and Bradley County Health Care and Rehabilitation Center in Cleveland, Tennessee. Section staff also completed the investigation of Banks-Jackson-Commerce Medical Center/Nursing Home in Commerce, Georgia, and sent a letter of findings to appropriate public officials. These investigations involved on site evaluation tours with expert consultants, review of documentary evidence and interviews of staff.

In 2002, the Division filed a joint motion to dismiss United States v. City of Philadelphia (E.D. Pa.), its CRIPA case involving conditions and practices at the Philadelphia Nursing Home. The court dismissed the case based on the demonstrated compliance of the City in meeting the terms of the consent decree.

In addition, the staff conducted a new CRIPA investigation of one residential facility for persons with developmental disabilities: New Lisbon Developmental Center in New Lisbon, New Jersey. Special Litigation Section staff conducted tours of the facility, accompanied by expert consultants, reviewed documents, and interviewed facility staff.

In 2002, the Section found that conditions and practices at two state-operated facilities for persons with developmental disabilities, Woodward and Glenwood Resource Centers in Iowa, violate the residents' federal constitutional and statutory rights. The Division informed the State that the psychiatric and psychological care and community placement programs at both Woodward and Glenwood failed to meet accepted professional standards and that Woodward is resorting to improperly restraining residents in lieu of adequate psychological and behavioral services, treatment, and training. Finally, the Division informed the Governor that the State is failing to ensure that residents at both facilities are being served in the most integrated setting appropriate to meet their individualized needs.

The Section continued its investigations of the following residential facilities for the developmentally disabled: Agnews and Sonora Developmental Centers in California; Pinecrest and Hammond Developmental Centers in Louisiana; Landmark Learning Center in Florida; Holly Center in Maryland; New Castle Developmental Center in Indiana; Rainier Residential Rehabilitation Center and Frances Haddon Morgan Centers in Washington; and Oakwood Developmental Center in Kentucky. In many of these investigations, negotiations toward settlement are continuing regarding the correction of remaining deficient conditions. In some of these matters, the Section is reviewing voluntary compliance to improve conditions.

The Section also initiated an investigation of four mental health facilities in North Carolina: John Umstead Hospital, Dorothea Dix Hospital, Cherry Hospital and Broughton Hospital. The Section continued to review compliance with a plan to correct identified deficiencies at Western State Hospital, a mental health facility in Staunton, Virginia.

The Section staff also conducted compliance reviews in ongoing CRIPA cases involving a variety of facilities: United States v. Tennessee (M.D. Tenn.) involving Clover Bottom Developmental Center, Harold Jordan Center, and Greene Valley Developmental Center; United States v. Tennessee (W.D. Tenn.) involving Arlington Developmental Center; United States v. Tennessee (D. Tenn.) involving the Memphis Mental Health Institute; United States v. New Mexico (D. N. Mex.) involving the New Mexico School for the Visually Handicapped; United States v. Connecticut (D. Conn.) involving Southbury Training School; United States v. Hawaii (D. Haw.) involving Hawaii State Hospital and the community mental health system; and United States v. Indiana involving Ft. Wayne Developmental Center and Muscatatuck Developmental Center in Indiana. The Section is continuing to pursue Evans and United States v. Williams (D. D.C.) which was filed prior to the passage of CRIPA and involves hundreds of community placements for members of the class with developmental disabilities in the District of Columbia. In each of these cases, staff reviewed compliance with the terms of previously filed agreements and court orders.

In addition to its law enforcement activities, the Special Litigation Section is responsible for representing the Civil Rights Division in the Department's health care fraud activities. The Section participates, for example, as a Department and Civil Rights representative on an inter-agency Nursing Home Steering Committee. The Section has also participated in public education and outreach by speaking and participating at both national and regional conferences on quality of care in health care facilities.

Justice Management Division

The Justice Management Division, Debt Collection Management Staff continues to perform for the Program various administrative and coordination duties. The duties of the office include: budget formulations, oversight and coordinating with the Office of Management and Budget and CMS; coordinating with HHS/OIG and the Department of the Treasury on the tracking of collections; coordinating with the GAO on required audits; and preparation and coordination of the annual report.

APPENDIX

Federal Bureau of Investigation
Mandatory Funding

"There are hereby appropriated from the general fund of the United States Treasury and hereby appropriated to the Account for transfer to the Federal Bureau of Investigation to carry out the purpose described in subparagraph (C), to be available without further appropriation - (I) for fiscal year 2002, $101,000,000."

The FBI works many health care fraud cases on a joint basis with other federal agencies, including the HHS/OIG. These two federal agencies collaborate through attendance at health care fraud working groups and each other's training conferences, case referral exchanges, and a liaison program between the two organizations. In addition, most health care fraud task forces formed by FBI field divisions represent the coordinated efforts among the FBI, MFCUs and state and local law enforcement, federal investigative agencies such as HHS/OIG, and private industry. The FBI and HHS/OIG continue to share a common commitment to ending fragmented health care fraud enforcement efforts and encouraging the coordination of investigative resources. The FBI, however, is the only federal investigative agency to have jurisdiction over both government sponsored health care programs and privately funded health care programs.

Under HIPAA, the FBI was provided $101 million in 2002 for health care fraud enforcement. As the FBI has increased the number of agents assigned to health care fraud investigations, the number of pending investigations has increased over 400 percent, rising from 591 cases in 1992 to 2,418 cases through 2002. Federal and state criminal health care fraud convictions resulting from FBI investigations have risen from 116 in 1992, to 549 through 2002. While the September 11, 2001 terrorist attacks temporarily affected the FBI's health care fraud enforcement program, health care fraud investigations remain a priority at the FBI. In 2002, the FBI sponsored training for approximately 100 agents having less than one year experience investigating health care fraud matters, advanced financial analysis training for health care support employees, and an advanced training covering the latest schemes and investigative techniques. In addition, the FBI recently dedicated additional training at Quantico for new agents to work on health care fraud matters.

The FBI continues to explore new ways to identify health care fraud. One of the innovative techniques initiated in 2002 by the FBI, in partnership with CMS, is the Medicare/Medicaid Data Analysis Center. This pilot project is analyzing claims made to both the federal Medicare and state Medicaid programs by the same providers in order to identify aberrant billing patterns, unusual growth in billings and/or utilization of services or treatments, billing for unusual time frames (i.e., more than 24 hours a day), and other indicia of potential fraud against both programs. Analysis from the project will be forwarded to the field divisions as health care referrals in previously undetected areas of fraud. The FBI expects to expand this pilot project in 2003.

A considerable portion of the increased funding was utilized to support major health care fraud investigations. In addition, operational support has been provided for FBI national initiatives focusing on pharmaceutical diversion, chiropractic fraud, medical clinics, and transportation providers. Further, the FBI continues to support individual field offices with equipment and to assist in various individual investigations.

GLOSSARY

The Account - The Health Care Fraud and Abuse Control Account

ACE - Affirmative Civil Enforcement

AoA - Administration on Aging

ASBTF - Assistant Secretary for Budget, Technology and Finance

CIA - Corporate Integrity Agreement

CMS - Centers for Medicare and Medicaid Services

CRIPA - Civil Rights of Institutionalized Persons Act

DME - Durable Medical Equipment

DOJ - The Department of Justice

FBI - Federal Bureau of Investigation

FCA - False Claims Act

FDA - Food and Drug Administration

FEHBP - Federal Employees Health Benefits Program

GAO - General Accounting Office

HHS - The Department of Health and Human Services

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

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

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

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

PAM - payment accuracy measurements

The Program - The Health Care Fraud and Abuse Control Program

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

SMP - Senior Medicare Patrol

TAG - Technical Advisory Group

USAO - United States Attorney's Office