
**The Department of Health and Human Services
And
The Department of Justice
Health Care Fraud and Abuse Control Program
Annual Report For FY 2008**

September 2009

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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 twelfth year of operation, the Program's continued success again confirms 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. Moreover, the Program's investment in criminal and civil health care fraud enforcement efforts has yielded an impressive "return on investment" for the American taxpayer: for every HIPPA dollar spent by DOJ and HHS on federal health care fraud enforcement, approximately \$4 has been recovered and returned.

Monetary Results

During FY 2008, the Federal Government won or negotiated approximately \$1 billion in judgments and settlements², and it attained additional administrative impositions in health care fraud cases and proceedings. The Medicare Trust Fund received transfers of approximately \$1.94 billion during this period as a result of these efforts, as well as those of preceding years, in addition to over \$344 million in Federal Medicaid money similarly transferred separately to the Treasury as a result of these efforts. The HCFAC account has returned over \$13.1 billion to the Medicare Trust Fund since the inception of the Program in 1997.

Enforcement Actions

In FY 2008, U.S. Attorneys' Offices opened 957 new criminal health care fraud investigations involving 1,641 potential defendants. Federal prosecutors had 1,600 health care fraud criminal investigations pending, involving 2,580 potential defendants, and filed criminal charges in 502 cases involving 797 defendants. A total of 588 defendants were convicted for health care fraud-related crimes during the year. Also in FY 2008, the Department of Justice (DOJ) opened 843 new civil health care fraud investigations and had 1,311 civil health care fraud matters pending.

¹Hereafter, referred to as the Secretary.

²The amount reported as won or negotiated only reflects federal recoveries and therefore does not reflect state Medicaid monies recovered as part of any global, federal-state settlements. Measures have been put into place to track such related state Medicaid recoveries.

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 2008**

**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.³ All funds deposited in the Trust Fund as a result of the Act are available for the operations of the Trust Fund.

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 the HHS/OIG, with respect to Medicare and Medicaid programs. In FY 2006, the Tax Relief and Health Care Act or TRHCA (P.L 109-432, §303) amended the Act so that funds allotted from the Account are 'available until expended'. TRHCA also allowed for yearly increases to the Account based on the change in the consumer price index for all urban consumers (all items; United States city average) or CPI-U over the previous fiscal year for fiscal years for 2007 through 2010. After 2010, the amount available in the Account will remain fixed at the 2010 level.

In FY 2008, the Secretary and the Attorney General certified \$255,196,557 for appropriation to the Account. A detailed breakdown of the allocation of these funds is set forth later in this report. HCFAC appropriations generally supplement the direct appropriations of HHS and DOJ

³Also known as the Hospital Insurance (HI) Trust Fund. All further references to the Medicare Trust Fund refer to the HI Trust Fund.

that are devoted to health care fraud enforcement and funded approximately two-thirds of the HHS/OIG's appropriated budget in FY 2008. (Separately, the Federal Bureau of Investigation (FBI) received \$120.9 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:

- (1) to coordinate federal, state and local law enforcement efforts relating to health care fraud and abuse with respect to health plans;
- (2) to conduct investigations, audits, inspections, 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, and suppliers.

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 FY 2008, \$2.14 billion was 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 during the fiscal year. The following chart provides a breakdown of the transfers/deposits:

Total Transfers/Deposits by Recipient FY 2008	
Department of the Treasury	
HIPAA Deposits to the Medicare Trust Fund	
Gifts and Bequests	\$25,847
Amount Equal to Criminal Fines	\$5,339,906
Civil Monetary Penalties	\$11,410,238
Asset Forfeiture *	0
Penalties and Multiple Damages	\$559,566,833
Subtotal	\$576,342,824
Centers for Medicare & Medicaid Services	
HHS/OIG Audit Disallowances - Recovered	\$662,456,511
Restitution/Compensatory Damages	\$703,493,134
Subtotal	\$1,365,949,645
Total	\$1,942,292,469
Restitution/Compensatory Damages to Federal Agencies	
TRICARE	\$14,499,978
Veteran's Administration	\$8,820,832
HHS/OIG Cost of Audits, Investigations and Compliance	
Monitoring	\$5,902,896
Office of Personnel Management	\$5,977,301
Other Agencies	\$6,105,516
Subtotal	\$41,306,523
Relators' Payments**	\$157,281,122
GRAND TOTAL ***	\$2,140,880,114

*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 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)(7) 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 of Title 31, United States Code (known as the False Claims Act, or 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).

PROGRAM ACCOMPLISHMENTS

EXPENDITURES

In the twelfth year of operation, the Secretary and the Attorney General certified \$255.197 million as necessary for the Program. The following chart gives the allocation by recipient:

FY 2008 ALLOCATION OF HCFAC APPROPRIATION⁴ (Dollars in thousands)	
Organization	Allocation
Department of Health and Human Services	
Office of Inspector General ⁵	\$169,736
Office of the General Counsel	5,714
Administration on Aging	3,128
Centers for Medicare & Medicaid Services (CMS)	22,997
Subtotal	\$201,575
Department of Justice	
United States Attorneys	\$30,400
Civil Division	\$14,539
Criminal Division	\$3,080
Civil Rights Division	\$2,376
Nursing Home and Elder Justice Initiative	\$1,000
Departmental Health Care Initiatives	\$2,227
Subtotal	\$53,622
Total	\$255,197

⁴In FY 2007, funds became ‘available until expended.’

⁵In addition, HHS/OIG obligated \$5.1 million 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

Overall Recoveries

During this fiscal year, the Federal Government won or negotiated approximately \$1 billion in judgments and settlements, and it attained additional administrative impositions in health care fraud cases and proceedings. The Medicare Trust Fund received transfers of approximately \$1.94 billion during this period as a result of these efforts, as well as those of preceding years, in addition to over \$344 million in Federal Medicaid money similarly transferred to the Treasury separately as a result of these efforts⁶.

In addition to these enforcement actions, numerous audits, evaluations and other coordinated efforts yielded recoveries of overpaid funds, and prompted changes in Federal health care programs that reduce vulnerability to fraud. In FY 2008, HHS collected approximately \$662.5 million in HHS/OIG recommended recoveries.

Departmental Collaboration

The Attorney General and the Secretary maintain regular consultation at both senior and staff levels to facilitate, coordinate and accomplish the goals of the Program. HHS and DOJ hold senior level meetings on a quarterly basis. These meetings provide a forum for the leadership of both Departments to ensure that the Program operates effectively, in coordination across various administrative, civil and criminal activities, and that any impediments to effective operation of the HCFAC program are minimized.

Similarly, the quarterly meetings between CMS and law enforcement entities (representatives include members of the Criminal Division, the Executive Office for the United States Attorneys (EOUSA), the Federal Bureau of Investigation (FBI), and HHS/OIG), provide an opportunity for staff from each agency to discuss and resolve operational issues which arise in the identification and prosecution of health care fraud schemes, as well as to provide timely updates on operational initiatives and programmatic changes which impact the Government's anti-fraud efforts.

In addition to the quarterly interagency meetings at the Departmental senior management and staff levels, EOUSA and CMS host a monthly national conference call during which Assistant United States Attorneys from all districts have the opportunity to interact directly with CMS representatives, receive timely reports on CMS operations, and obtain answers to questions related to specific issues regarding current investigations. The Departments also convene interagency staff-level working groups as needed to develop mutual proposals for improving our health care fraud fighting capabilities.

⁶ Note that some of the judgments, settlements, and administrative actions that occurred in FY 2008 will result in transfers in future years, just as some of the transfers in FY 2008 are attributable to actions from prior years.

Each Department routinely enlists senior staff from the other to participate in staff training programs, thereby encouraging the free-flow of shared expertise and accessibility. The Department of Justice's Criminal Division and HHS/OIG initiated a special program in 2007, which provides an opportunity for HHS/OIG counsel to serve 6 month details to gain experience managing criminal health care fraud investigations and trial experience in Federal court with Criminal Division colleagues. That program continues.

During FY 2008, the many significant HCFAC Program accomplishments included the following:

Medicare Fraud Strike Force

The Medicare Fraud Strike Force (Strike Force) was launched in March 2007 as part of the South Florida Initiative, a joint investigative and prosecutive effort against health care fraud in South Florida. The Strike Force builds upon earlier phases of the multiagency and multidisciplinary initiative to combat Medicare fraud and abuse among durable medical equipment (DME) suppliers and HIV infusion therapy providers. In its initial phase, HIV infusion therapy clinics and DME companies suspected of fraud were identified, investigated, and pursued for civil violations. Providers identified through these efforts were also investigated and pursued for criminal violations. The Strike Force is using real-time analysis of Medicare billing data, as well as findings from investigations, in its ongoing efforts to identify, investigate, and prosecute individuals and companies that have committed DME fraud. Based on the success of these efforts, a second phase of Strike Force operations began in Los Angeles in March 2008. Strike Force accomplishments from cases prosecuted in both phases during FY 2008 follow⁷:

30 cases indicted involving charges filed against 65 defendants who collectively billed the Medicare program more than \$140 million

67 guilty pleas negotiated and seven jury trials litigated, winning guilty verdicts on all charges filed against eight defendants⁸

Imprisonment for 71 defendants sentenced during the fiscal year, averaging more than 40 months of incarceration, and sentences to probation for another seven defendants ranging from 12 to 60 months.

In the year and a half since its inception, Strike Force prosecutors filed 104 cases charging 185 defendants who collectively billed the Medicare program more than half a billion dollars; 106

⁷ Figures for guilty pleas and imprisonment sentences include defendants who may have been charged in Strike Force cases filed the previous year but whose plea negotiations or sentences occurred in FY 2008.

⁸Two other defendants were acquitted at trial.

defendants pleaded guilty and 12 others were convicted in jury trials; and 104 defendants were sentenced to imprisonment for an average term of 43 months.

Examples of successful initiatives of the South Florida Initiative and the Strike Force include the following:

Durable Medical Equipment Fraud in South Florida

- DME company owners were sentenced for conspiring to defraud the Medicare program by submitting false claims for medically unnecessary DME items and supplies, including aerosol medications and oxygen concentrators. The companies paid kickbacks to a physician previously investigated by HHS/OIG, and to several Medicare beneficiaries in order to use their Medicare numbers to submit the fraudulent claims. The 13 convicted DME company owners involved in the scheme were ordered to pay a total of more than \$6.4 million in restitution and \$132,000 in fines and assessments. The 13 subjects were also sentenced to various terms of imprisonment, probation, and/or home detention, the longest prison sentence for the case being 6 years and 6 months.
- After a five-week trial, a Federal jury in Miami convicted three owners of two DME companies, a home health agency and an assisted living facility which conspired to defraud Medicare of more than \$14 million for unnecessary medicine, DME, and home health care services. Two defendants were sentenced to 51-month terms of imprisonment, and the third was sentenced to a 31-month prison term. Patients testified at trial that they took kickbacks, were falsely diagnosed with chronic obstructive pulmonary disease and prescribed unnecessary aerosol medications, including commercially unavailable compounds. A fourth co-defendant who was a dermatologist, was also convicted in a separate jury trial and was sentenced to prison for 41 months.
- The owner of a DME company was sentenced to 151 months in prison and ordered to pay over \$3.4 million in restitution. The owner was convicted by a Federal jury for his scheme involving fraudulent prescriptions for non-commercially-available aerosol medications so that they could be illegally “compounded.” The unapproved medications were then billed to the Medicare program. Pharmacy owners involved in the scheme returned half of the Medicare reimbursement to the DME company owner for each fraudulent prescription. Patients and physicians involved in the fraud scheme were also paid cash kickbacks.
- A Federal jury in Miami convicted the owner of two DME companies for his role in a \$4.6 million Medicare fraud scheme and for money laundering. The owner billed the Medicare program for negative pressure pumps, wound care supplies, and other DME. Physicians testified at trial that they never prescribed the types of equipment for which Medicare was billed in the scheme. Other witnesses testified that the defendant opened DME companies in the names of nominee owners and brokered the purchase and sale of DME companies for the purpose of “burning Medicare” by submitting high volumes of fraudulent claims submitted within a two- to three-week time period. The defendant was sentenced to a

130-month term of imprisonment and ordered to pay restitution of nearly \$2 million. After being placed on home confinement with electronic monitoring, the defendant violated the terms of his post-trial release and fled the country. Another co-defendant also remains a fugitive.

- The owner of a DME company was sentenced to 30 months' incarceration and ordered to pay \$1.4 million in restitution for health care fraud. From April 2006 through October 2006, the owner billed Medicare for DME that was never ordered by physicians or never provided to beneficiaries.
- The owner of a DME company was sentenced to 51 months in prison and ordered to pay \$853,000 in restitution. The owner billed the Medicare program for diabetic supplies, pressure-reducing air mattresses, and other health care supplies purportedly provided to beneficiaries.

HIV Infusion Clinic Fraud in South Florida

- A physician's assistant pleaded guilty and was sentenced to 14 years of imprisonment for his part in \$119 million HIV infusion fraud conspiracy; three other co-defendants remain fugitives. The physician's assistant admitted to training physicians at eleven fraudulent HIV infusion clinics to prepare and submit medically unnecessary HIV infusion services that were allegedly administered to Medicare patients. He also admitted to overseeing the documentation of fraudulent services to make it appear that the clinics provided legitimate services, and to knowing that the infusion treatments billed at the clinics were medically unnecessary and/or were never provided.
- A physician and the administrator of an HIV infusion clinic pleaded guilty for their roles in a \$37 million infusion fraud scheme. The physician, who was sentenced to 84 months in prison, admitted to approving approximately \$26 million worth of fraudulent medical bills, signing documents containing false information about treatments purportedly provided to HIV patients, and approving medically unnecessary treatments. The clinic administrator, who was sentenced to serve 70 months in prison, admitted to causing the submission of approximately \$11 million in false claims to the Medicare program, paying health care kickbacks, and committing health care fraud.
- A former owner of a Miami pharmacy, who is currently serving a 63-month prison sentence for a previous Medicare fraud conviction, pleaded guilty to participating in a conspiracy to launder approximately \$3.8 million in proceeds from several other health care fraud schemes. The defendant assisted others in laundering the proceeds of Medicare fraud obtained through two Miami medical clinics purporting to specialize in the treatment of HIV patients. The defendant admitted to knowing that the clinics submitted fraudulent claims to the Medicare program for HIV services purportedly provided to Medicare beneficiaries, and admitted to assisting others in concealing their control of the clinics' fraudulently-obtained Medicare funds. In the previous case, the defendant pleaded guilty to charges that he conspired to pay kickbacks to 72 owners of DME companies in

exchange for prescriptions for compounded aerosol medications and related DME for which he received more than \$4.5 million in payments from Medicare

- An individual was sentenced to 54 months in jail and ordered to pay more than \$3.3 million in restitution for her involvement in a health care fraud scheme. The defendant, who owned and operated a clinic, billed Medicare for fraudulent infusion therapy services and paid kickbacks to beneficiaries for the use of their Medicare number in order to fraudulently bill Medicare.
- Two owners of a billing company and an employee were sentenced for conspiracy to commit health care fraud. The two owners were each sentenced to 14 years' incarceration and the employee was sentenced to 11 years. The three conspired to bill Medicare nearly \$420 million in DME purported to have been provided to Medicare beneficiaries by 85 DME companies. These claims were for equipment that had not been ordered by physicians or delivered to the beneficiaries as claimed.

Other Durable Medical Equipment Fraud

- A Texas physician was sentenced to 78 months in prison and ordered to pay more than \$6.5 million in restitution for participating in a fraud scheme involving DME. The physician and three other defendants were convicted after a 6-week trial, and a fifth defendant pleaded guilty. The defendant and another physician were paid by DME company owners to authorize motorized wheelchairs for beneficiaries who had no medical necessity for them. The DME company owners in turn billed Medicare for motorized wheelchairs, but delivered significantly less expensive scooters to the beneficiaries. In total, the five defendants were sentenced to a total of more than 380 months' imprisonment and ordered to pay more than \$18 million in restitution.
- In Texas, the owner of a medical equipment supplier was sentenced to 24 months in prison and ordered to pay \$4.4 million in restitution for her role in a health care fraud kickback scheme. The owner paid runners between \$800 and \$1,000 for each certificate of medical necessity (CMN) that physicians signed. The owner then used the fraudulent CMNs to bill Medicare and Medicaid for power wheelchairs provided to beneficiaries that were not medically necessary.
- In West Virginia, Group II Medical Supports, LLC, a local durable medical equipment supplier, along with owners and officers, agreed to pay the United States in excess of \$2.5 million to resolve allegations that defendants routinely supplied high cost mattresses developed to treat the most advanced and serious forms of pressure ulcers or bed sores, to Medicare and Medicaid patients who did not have the required ulcers and otherwise did not qualify. To facilitate this scheme, defendants misrepresented individual patients' conditions and diagnoses and created false documents that were used to support Medicare and Medicaid claims for payment.

- In Georgia, a respiratory therapist was sentenced to 5 years in prison and ordered to pay \$2.7 million in restitution for conspiracy to commit health care fraud. The respiratory therapist, who worked in a hospital, provided false blood test results for patients so a DME provider could in turn bill Medicare and Medicaid for unnecessary oxygen treatments.

Fraud by Physicians

- A Florida physician was sentenced to 18 months in prison and ordered to pay more than \$5.1 million in restitution after pleading guilty to one count of conspiracy to commit health care fraud. The physician, while serving as the medical director of an HIV clinic, authorized and approved the use of the drug WinRho, along with a mix of various vitamin supplements, for each HIV patient he was seeing, knowing that the HIV patients did not need WinRho and that the drug could actually harm them. The physician approved over \$7 million worth of fraudulent medical bills for submission to Medicare.
- A Texas orthopedic surgeon agreed to pay more than \$3.1 million and enter into a 5-year CIA to resolve allegations of Medicare and Medicaid fraud brought against him and hospitals with which he was affiliated and in which he had an ownership interest. The Government's investigation, initiated with information presented in a qui tam suit, found that the surgeon and an affiliated hospital billed Medicare and Medicaid programs for services not rendered as represented. Also, the Government alleged that the surgeon and another affiliated hospital obtained inflated payments from the Medicare program by billing postsurgical patients as though they had been discharged to home, when, in fact, they had been discharged to a rehabilitation facility for continuing treatment.
- A Michigan dermatologist was sentenced to 10 years and 6 months in prison and ordered to pay \$1.3 million in restitution and a \$175,000 fine following a jury trial conviction for health care fraud. The dermatologist falsely informed patients that they had cancer and performed unnecessary procedures when, in fact, laboratory results indicated that their tissue specimens were benign. In addition, the defendant billed for unnecessary follow-up office visits, claiming that beneficiaries had developed postoperative infections, such as impetigo, a disease rarely seen in adults. Finally, the dermatologist reused single-use needles and sutures without proper sterilization and failed to properly sterilize surgical equipment used in procedures. HHS/OIG assisted the local health department in informing patients of their possible risk of contracting a blood-borne pathogen, such as hepatitis B or C or HIV, because of his unsanitary medical practices.
- An Ohio physician was sentenced to 37 months in prison after pleading guilty to conspiring to engage in a scheme to defraud Medicare and other health care benefit programs by performing medically unnecessary nuclear stress tests that involved injecting nuclear medicine into patients. During the conspiracy, the physician received at least \$1.8 million in reimbursement for the medically unnecessary tests. As part of his guilty plea, the physician agreed to give up his medical license, to forfeit more than \$1.8 million, and to be permanently excluded from participation in all federal health care programs.

- In Oregon four cardiac surgeons specializing in complex heart bypass and transplant surgeries have agreed to pay the United States \$2.5 million to settle claims that the practice submitted false claims to federally-funded health programs, including Medicare and Medicaid, for the services of additional surgeons. During the period in question, the four surgeons submitted claims for assistant surgeons regardless of whether a second surgeon provided any assistance during the surgery or was even present for the operation. As a part of a global resolution of all criminal, civil and administrative claims against the doctors, the United States and the State of Oregon agreed to defer prosecution of the four surgeons for a period of eighteen months in return for the doctors' agreement to enter into a Diversion Agreement with the District of Oregon Office of Pretrial Services.

Fraud by Dentists

- Medicaid Dental Center (MDC), a privately-owned chain of dental clinics in North Carolina, has agreed to pay more than \$10 million to resolve allegations that it billed the State Medicaid program for medically unnecessary dental services performed on indigent children. The United States and the State alleged that MDC and its owners were liable for submitting claims for reimbursement for performing pulpotomies that were not medically necessary. Pulpotomies are considered medically necessary in pediatric dental cases when an infection in a tooth spreads into the pulp chamber of the tooth, requiring the pulp's removal.

Fraud by Other Practitioners

- A Pennsylvania physical therapist was sentenced to 6 months' incarceration and ordered to pay more than \$1.2 million in restitution for billing Medicare for work that was not performed. From January 1, 2000, through December 31, 2002, the physical therapist submitted claims that would have required working more than 15 hours a day, and often more than 24 hours a day, for more than 600 days.
- A Maryland podiatrist agreed to pay the Government more than \$534,000 plus interest, and entered into a 5-year integrity agreement with HHS/OIG, to resolve allegations of false Medicare and Medicaid billing. The podiatrist allegedly billed Medicare and Maryland Medicaid for evaluation and management services not provided and for non-covered services. The Maryland State Board of Podiatric Medical Examiners, after conducting its own investigation, suspended the podiatrist's medical license in Maryland for 2 years (with 1 year stayed).
- In New Jersey, a podiatrist was sentenced to 24 months in prison and ordered to pay \$350,000 in restitution for performing routine foot care on residents in community rooms of low-income buildings then billing the Medicare program as if he performed more complex procedures. In fact, residents were only getting their nails clipped. At the height of the podiatrist's fraudulent activities, he was the highest paid podiatrist in the New York and New Jersey area, being paid as much as \$1.6 million in 2005. In August 2007, the podiatrist agreed to pay \$868,000 to resolve his False Claims Act liability for the same conduct.

- In Illinois, a psychologist was sentenced to 22 months in prison and ordered to pay \$170,000 in restitution for billing Medicare for group and individual psychotherapy services that he did not provide. The psychologist, who visited facilities once or twice a week to conduct assessments, billed Medicare for psychotherapy services provided to patients 4 to 5 days a week that were either not performed as billed or were for dates of service when he was not actually present at the facilities. In 2005, the psychologist fled the U.S. to Israel. In April 2007, he was arrested by Israeli authorities and in September he was extradited back to the U.S. where he pled guilty.

Pharmaceutical Fraud

- Cephalon, Inc., entered a global criminal, civil, and administrative settlement under which the company agreed to pay a total of \$425 million plus interest; plead guilty to a misdemeanor violation of the Federal Food, Drug and Cosmetic Act; and enter into a comprehensive 5-year CIA with HHS/OIG. The civil settlement resolves allegations filed in four separate qui tam cases, which alleged that Cephalon promoted the drugs Actiq, Gabitril, and Provigil for “off-label” uses (that is, uses other than those approved by FDA). Cephalon’s off-label promotional practices involved a variety of techniques, including training its sales force to disregard restrictions of the FDA-approved label and promote the drugs for off-label uses. In addition to the \$375 million civil settlement, Cephalon entered into a criminal plea agreement with the United States under which it will pay \$50 million.
- Merck and Company (Merck), Inc., agreed to pay \$399 million plus interest to resolve allegations that Merck failed to properly include discounts on Vioxx (no longer marketed), Zocor, and Mevacorin in the “best prices” reported to CMS under the Medicaid drug rebate program and, as a result, underpaid rebates owed to the States and overcharged entities that purchased Merck products under the 340B Drug Pricing Program. The United States alleged that Merck sales representatives induced physicians to use its drug products by making, among other forms of illegal remuneration, payments that were disguised as fees for training, consultation, or market research. Merck agreed to this settlement at the same time it settled a matter in Louisiana, involving similar discounted pricing programs offered to hospitals for another Merck drug, Pepcid. Through both settlements, Merck agreed to pay a total of \$649 million plus interest. Merck further agreed to enter into a 5-year CIA with HHS/OIG that includes corrective measures to address its conduct in both cases.

Fraud by Pharmacies

- CVS Caremark Corporation (CVS) agreed to pay \$36.7 million and enter into a 5-year CIA with HHS/OIG to resolve its liability based on allegations that it fraudulently overcharged Medicaid programs in 23 States by improperly switching drugs it dispensed. Specifically, the Government and relator alleged that CVS dispensed ranitidine (generic Zantac) capsules rather than tablets in order to increase its reimbursement from Medicaid. As a result of dispensing and billing Medicaid for capsules, CVS was reimbursed, on average, four times what it would have been reimbursed had it dispensed tablets.

- Walgreens Co. (Walgreens) agreed to pay the United States, 42 States, and Puerto Rico more than \$35 million to settle Medicaid prescription drug fraud claims. The qui tam complaint alleged that Walgreens substituted different forms of generic prescription drugs for others (such as tablets for capsules) solely to increase its reimbursement rate rather than for any legitimate medical reason. The drugs at issue were ranitidine (generic Zantac), fluoxetine (generic Prozac), and selegiline (generic Eldepryl). The Government further alleged that Walgreens' systematic substitution of more expensive forms of these drugs for less expensive, prescribed forms was motivated by its intent to avoid CMS' Federal Upper Limit (FUL) on prices for the drugs and States' maximum allowable costs (MAC) for the drugs. In addition to the monetary settlement, Walgreens entered into a 5-year CIA that requires an independent review organization to review its Medicaid reimbursement for generic drugs for which Government reimbursement is limited by FUL and MAC lists.
- In another matter, Walgreens paid the United States and four participating states \$9.9 million to resolve False Claims Act allegations that it falsely billed the Medicaid program. Walgreens submitted claims to Medicaid agencies in four states for prescription drugs dispensed to persons covered for such claims both by Medicaid and by private third-party insurance. Walgreens was reimbursed by Medicaid in an amount equal to the difference between what the third-party insurance paid when the claims were submitted and what the states' Medicaid programs would have paid in the absence of third-party insurance. The claims were false because Walgreens was entitled to reimbursement from the Medicaid programs in an amount equal only to the amount the insured would have been obligated to pay had the claims been submitted solely to the third party insurer providing coverage, i.e. the co-payment amount, yet it knowingly submitted claims in excess of that amount. As a result of this improper billing, Walgreens received reimbursement amounts from the states Medicaid programs that were higher than it was entitled to receive.
- Four institutional pharmacies owned by Omnicare, Inc., agreed to pay nearly \$3.5 million and enter into an amendment to a preexisting CIA to settle allegations of improper Medicaid billing. The pharmacies allegedly double-billed the Michigan Medicaid program for drugs provided to hospice patients. In Michigan, Medicaid pays hospice providers a flat fee that includes all medications that are related to a hospice patient's terminal diagnosis. Drugs not related to the terminal diagnosis are not included in this flat fee, and the pharmacy must bill Medicaid directly for these other drugs. The underlying qui tam complaint alleged that the pharmacies knowingly billed Medicaid for all drugs that it dispensed to hospice patients, including those drugs already reimbursed through the flat fee paid by Medicaid to the hospice, thus causing Medicaid to pay twice for the same drugs—one payment to the hospice provider and another payment to the pharmacy.

Hospital Fraud

- Staten Island University Hospital (SIUH) paid nearly \$89 million in a global settlement resolving allegations that it defrauded Medicare, Medicaid, and TRICARE. The global

settlement resolves two separate qui tam lawsuits and two Government investigations. As part of the global settlement, SIUH also entered into a 5-year CIA with HHS/OIG.

- ▶ In the first lawsuit, the Government's investigation alleged that SIUH submitted claims for payment for treatment provided to patients in beds for which SIUH had received no certificate of operation from the New York State Office of Alcoholism and Substance Abuse Services and concealed the existence of those beds from that office. SIUH paid nearly \$12 million to the United States and nearly \$15 million to the State of New York.
- ▶ In the second lawsuit, the investigation alleged that SIUH knowingly used incorrect billing codes for certain cancer treatments performed at the hospital, and thus obtained reimbursement for treatment that was not covered by Medicare or TRICARE. SIUH will pay \$25 million to settle this lawsuit.
- ▶ Additional conduct self-disclosed by SIUH was resolved prior to the filing of the lawsuits. Pursuant to HHS/OIG's Self-Disclosure Protocol, SIUH agreed to nearly \$36 million for reporting inflated counts of medical residents in its cost reports for 1996 through 2003.
- Saint Joseph's Hospital of Atlanta, Inc., and St. Joseph's Health System, Inc. (collectively, "SJHS"), paid \$26 million, including interest, and enter into a 5-year CIA with HHS/OIG to resolve allegations raised in a qui tam complaint that from 2000 through 2005, the hospital improperly billed Medicare for inpatient admissions and other services. The allegations concerned primarily the submission of claims that should have been billed as "outpatient visits" but were instead billed at the higher rate as "inpatient admissions." In addition, under a separate agreement, SJHS will pay the Government an amount expected to be between \$3 million and \$4 million (the precise figure to be determined by an independent auditor) to cover Medicare overpayments for admissions in 2006 that it improperly billed as inpatient stays.
- In Connecticut, Yale-New Haven Hospital entered into a civil settlement agreement with the Government in which it will pay approximately \$3.8 million to resolve allegations that it violated the FCA. These allegations involved charges to Medicare for infusion therapy, chemotherapy administration and blood transfusion services. During the time-period at issue, Medicare only allowed payment for one unit of infusion therapy and chemotherapy administration per patient visit, and one unit of blood transfusion services per day.
- The University of Pennsylvania Health System (UPHS) paid \$3.5 million to resolve allegations that UPHS had erroneously submitted separate and distinct Medicaid payment claims for blood transfusions on bills that had more than one unit per day. Further, UPHS allegedly submitted fraudulent claims associated with office visits for new patients, as well as fraudulent claims for infusion therapy. UPHS is the 20th hospital to settle under the 3-year-long "Operation Vampire" project, aimed at uncovering hospitals' erroneous Medicare claims associated with blood transfusions. Including this case, Operation Vampire recoveries total approximately \$12.5 million.

- In Connecticut, Yale-New Haven Hospital entered into a civil settlement agreement with the Government in which it will pay approximately \$3.8 million to resolve allegations that it violated the FCA. These allegations involved charges to Medicare for infusion therapy, chemotherapy administration and blood transfusion services. During the time-period at issue, Medicare only allowed payment for one unit of infusion therapy and chemotherapy administration per patient visit, and one unit of blood transfusion services per day.

However, on many occasions, Yale-New Haven Hospital billed Medicare for multiple units of these services. Instead of billing for one unit per patient visit or one unit per day, Medicare was often billed for between two and five units. The allegations also involved claims for services provided in Yale-New Haven Hospital's Oncology Infusion Service that were not adequately documented in the patients' medical records, including dispensing medication and conducting laboratory studies without written orders signed by a physician.

- Henrietta Goodall Hospital paid \$1.15 million to resolve allegations that the hospital overbilled Medicare by improperly coding for the drugs Herceptin, Tenecteplase, and Paclitaxel. The Government also alleged that the hospital's prior management knew or should have known the billing was improper because the billing irregularities had been identified by certain former employees, but the hospital failed to take the necessary corrective action.
- Tomball Regional Hospital (Tomball) and a physician co-defendant paid over \$816,000 to resolve their liability for allegedly submitting false or fraudulent Medicare and Medicaid claims for hyperbaric oxygen (HBO) therapy. Tomball also entered into a 5-year CIA with HHS/OIG. The investigation was predicated on information received from a qui tam complaint filed by a former hospital employee, who alleged that Tomball submitted claims for HBO therapy when the patients' conditions did not warrant payment by Medicare and Medicaid, the documentation failed to support the diagnosis code billed, and/or the services were not rendered.

Cost Report Fraud

- Cooper University Hospital in Camden, N.J., has paid the United States \$3.85 million, plus interest, to settle allegations that it improperly increased charges to Medicare patients to obtain enhanced reimbursement for care that is extraordinarily costly, called "outlier payments."
- Besler & Company, Inc., a health care consulting firm; its principal; and related entities (collectively, Besler) paid \$2.87 million to resolve allegations arising from two qui tam lawsuits, which alleged that Besler caused hospitals to falsely bill Medicare for excessive inpatient and outpatient outlier payments. The Government alleged that Besler advised hospitals to artificially inflate their cost-to-charge ratios, triggering outlier payments to which they were not entitled.

- The buyer of Bayonne Medical Center in New Jersey has agreed to settle for \$2.5 million, plus interest, allegations made in a qui tam complaint that it defrauded the Medicare program by improperly increasing charges to Medicare patients in order to obtain enhanced outlier payment reimbursement from Medicare. In 2007, Bayonne Medical Center filed for bankruptcy under Chapter 11 of the Bankruptcy Code. As part of the proposed reorganization, IJKG, LLC agreed to purchase the hospital's assets and to settle the United States' claims against the hospital.
- BlueCross BlueShield of Tennessee (BCBS-T) has paid the United States \$2.1 million to settle allegations that it violated the False Claims Act when it, with deliberate ignorance or reckless disregard of available information, failed to adjust the cost-to-charge ratios for many New Jersey hospitals in a timely manner. This resulted in the payment of excessive outlier payments by Medicare program to those medical facilities.

Kickbacks

- Lester E. Cox Medical Centers, a health care system headquartered in Missouri, has paid \$60 million and entered into a 5-year CIA with HHS/OIG to settle allegations that it paid doctors at a local physician group for referrals, and billed Medicare for the services resulting from those referrals, in violation of the Anti-Kickback and Physician Self-Referral statutes.
- HealthSouth and two physicians paid \$14.9 million to settle allegations that they submitted false claims to Medicare and paid illegal kickbacks to physicians who referred patients for care in HealthSouth hospitals, outpatient rehabilitation clinics, and ambulatory surgery centers. HealthSouth paid \$14.2 million and agreed to amend its CIA with the HHS/OIG to address kickback issues. Two orthopedic surgeons paid \$450,000 and \$250,000 respectively to resolve the Government's claims against them. The settlement resolves claims made by HealthSouth to Medicare for patients referred by the two surgeons when the company had financial relationships with the physicians, their former sports medicine and orthopaedic clinic, and their research and training foundation, that violated the Anti-Kickback and Physician Self-Referral Statutes. The HealthSouth settlement also resolves allegations that the company paid kickbacks to and entered into improper financial relationships with other physicians, including a group in Los Angeles, California, in an apparent attempt to induce the referral of patients. The Government's investigation of certain of the other physicians is continuing. The underlying conduct was disclosed by HealthSouth under the HHS/OIG's Self-Disclosure Protocol.
- Touro Infirmary, a New Orleans Hospital, paid \$1.75 million to settle allegations that it made unlawful payments, through consultant and medical directorship contracts, to a psychiatrist to induce her to refer patients to the hospital. The Government pursued criminal charges against the psychiatrist, and a jury returned guilty verdicts on 39 counts of health care fraud, including 13 counts arising from her contractual relationship with Touro.

- A New Jersey cardiologist paid more than \$1.4 million to settle allegations of taking a salary from the University of Medicine and Dentistry of New Jersey (UMDNJ) in exchange for making referrals. The payments were ostensibly for clinical faculty services, services that the cardiologist admittedly did not perform. In exchange for the salary, the cardiologist would refer patients to UMDNJ's University Hospital for cardiac services.
- A California man was sentenced to 1 year and 1 week in prison and ordered to pay more than \$1.3 million in restitution following his guilty plea to allegations that, as a "capper" he was paid to recruit Medicare beneficiaries who were transported to a fraudulent medical clinic. The individual would then pay the beneficiaries following the provision of medically unnecessary services. A second capper in the scheme was sentenced to 3 months' home detention and ordered to pay approximately \$5,500 in restitution for a guilty plea. Additionally, the man's mother was sentenced to 6 months' home detention and ordered to pay more than \$2,800 in restitution for lying to Federal agents during the investigation.

Prohibition on Self Referrals

- A Florida physician and his wholly owned imaging centers and related entities paid \$7 million plus interest to resolve several allegations that, among other improper conduct, the physician and the imaging centers entered into financial relationships or arrangements with certain referring physicians in violation of the Physician Self-Referral Law and the Anti-Kickback Statute, and billed Medicare for several diagnostic studies that were not performed, not ordered, or not medically necessary. The physician, individually and on behalf of the affiliated imaging centers and related entities, entered into a 5-year CIA with HHS/OIG that includes an Arrangements Review.
- Memorial Health, Inc., Memorial Health University Medical Center, Inc., Provident Eye Physicians, Inc., and Georgia Eye Institute, Inc. (collectively, Memorial), paid \$5.08 million to resolve allegations that the Georgia-based entities violated the Physician Self-Referral law through excessive payments made to its employee ophthalmologists. Memorial disguised such payments as teaching stipends or payments for indigent care.

Medicaid Fraud

- Amerigroup Corporation paid \$225 million, and entered into a 5-year CIA with HHS/OIG, to resolve False Claims Act claims that it systematically avoided enrolling pregnant women and unhealthy patients in their Medicaid managed care program in Illinois. Amerigroup was paid by the United States and the State of Illinois to operate a Medicaid managed care health plan to provide health care to low income people. Amerigroup was required by law to enroll all eligible beneficiaries. As reported last year, a federal Court in Chicago entered a judgment in 2007 against Amerigroup for \$144 million in damages and \$190 million in penalties. Amerigroup appealed that judgment and this settlement resolves that appeal.

- The owner of a Wisconsin company that provided pre-natal and child care coordination services was sentenced to 5 years in prison and ordered to pay more than \$320,000 in restitution for billing the Medicaid program for services never rendered or for non-covered services. In 2005, the Wisconsin Medicaid program reimbursed the company in excess of \$2 million. Four co-defendants were previously sentenced related to their role in fabricating documents.

Other Fraud

- Medtronic Spine LLC, the corporate successor to Kyphon Inc., paid the United States \$75 million and entered into a 5-year CIA with HHS/OIG to settle FCA allegations that it, through a seven-year marketing scheme, caused hospitals to bill Medicare for certain kyphoplasties performed on an inpatient basis rather than less costly and clinically appropriate outpatient kyphoplasty treatment. The kyphoplasty procedure is a minimally-invasive surgery used to treat compression fractures of the spine caused by osteoporosis, cancer or benign lesions.
- The Government secured a default judgment of more than \$6.2 million against an ambulance service and its owner following allegations that the defendants submitted false or fraudulent claims to Medicare for non-emergency ambulance services. The case was predicated on an HHS/OIG audit of ambulance transport services in Puerto Rico that had identified potential false claims by the company and its owner.
- In California, Greybor Medical Transportation, Inc. agreed to pay approximately \$7 million in settlement of alleged violations of the FCA by the ambulance provider and its owners. Defendants billed for ambulance transportation (1) that did not occur, (2) that did occur but was not provided to eligible Medicare beneficiaries, and (3) that did occur, but was provided to patients as a group and then billed for patients individually at a higher rate. In addition to a \$6 million cash payment, defendants waived their right to approximately \$1 million in approved Medicare payments being held in a suspense account.
- The two owners of a physical therapy provider were sentenced to 37 and 48 months in prison, respectively, and ordered to pay restitution in excess of \$4.5 million, for submitting false physical therapy claims to Medicare and Medicaid. The scheme involved the Mississippi provider of physical therapy services submitting claims for services provided by unlicensed, untrained, and unsupervised individuals, rather than by a physician or a licensed physical therapist. The two individuals also owned and operated another facility, which was operated in the same manner.
- Dianon Systems, Inc. (Dianon), paid \$1.5 million to resolve allegations that the Connecticut company improperly billed Medicare and the Department of Defense's TRICARE program for certain tests that it performed. Dianon is a reference laboratory that specializes in conducting tests to detect and stage various types of cancer. A qui tam

complaint alleged that Dianon billed Medicare and TRICARE for 26 flow cytometry tests on every sample sent to the company for diagnosis regardless of whether all 26 were medically necessary for a particular patient.

- Martin Luther Memorial Homes, Inc. (MLMH), paid \$550,000 to resolve its allegations that the Michigan nursing home operator violated the FCA by creating another entity, Lutheran Ancillary Services (LAS), to provide physical, occupational, and speech therapy services, as well as pharmacy supplies, to the residents of MLMH's nursing homes and failing to disclose this relationship to Medicare. LAS billed MLMH for the therapy services at inflated rates, which MLMH then incorporated into its 1997 and 1998 Medicare cost reports, and then failed to adjust the amounts paid to LAS as required for transactions among related parties. MLMH currently operates only private-pay facilities, and a 5-year CIA with the OIG will become operative if it bills any Federal health care program.
- In Pennsylvania, the Court approved a Consent Order resolving a Complaint for Injunctive Relief against Holland Glen, a residential treatment nursing facility for respirator dependent children. In that complaint, the United States alleged that Holland Glen, which was licensed only as a community group home for mentally disabled persons, not as a nursing facility, defrauded the United States by providing substandard nursing care or failing to provide nursing care, including failure to respond to respiratory alarms, failure to comply with physician orders for pulse oximeters, failure to prevent severe bed sores, and failure to administer medications properly. According to the complaint, Holland-Glen's services substantially departed from generally accepted professional standards of care, thereby exposing patients to significant risk and, in some cases, to actual harm. Many of the 20 to 30 residents at the facility require ventilators and are fed through feeding tubes. Most of the child-residents require around-the-clock medical attention. The Consent Order granted permanent injunctive relief including: the appointment of an independent manager of all facilities owned by Holland Glen; that Holland Glen will comply with the quality of care standards contained in the federal nursing home facility regulations (never before applicable to a children's facility); and that the temporary monitors would continue to monitor the care. The Consent Order also barred Holland Glen's President/CEO and Board of Directors from any management or oversight roles.
- In Michigan, Ciena Healthcare Management, Inc., a corporation that manages thirty long-term care/skilled nursing facilities, its owner, its Chief Financial Officer, and Chief Operating Officer, paid \$1.2 million to settle allegations that they improperly billed Medicaid and Medicare for inadequate care of, and services to, residents at four of its metro Detroit nursing homes. Several of the Ciena facilities failed to meet the needs of residents in: (1) nutrition and hydration, (2) the assessment and evaluation of needs, (3) care planning and nursing interventions, (4) medication management, (5) fall prevention, and (6) pressure ulcer care, including the prevention and treatment of wounds. The defendants also collectively entered into a five-year corporate integrity agreement, at an estimated cost of \$2.5 million, that requires the company to undertake certain measures to promote compliance with the requirements of Medicare, Medicaid, and all other Federal health care programs in each of the thirty Ciena managed facilities.

FUNDING FOR THE 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 the HHS/OIG⁹. In FY 2008, The Secretary and the Attorney General jointly allotted \$169.736 million to the HHS/OIG.

The HHS/OIG participated in investigations or other inquiries that resulted in 917 prosecutions or settlements in FY 2008, of which 792, or 86 percent, were health care cases. A number of these are highlighted in the Accomplishments section. During FY 2008, the HHS/OIG also excluded a total of 3,129 individuals and entities, barring them from participating in Medicare, Medicaid, and other Federal and state health care programs. In addition, the Department of Health and Human Services collected approximately \$662.5 million in disallowances of improperly paid health care funds, based on HHS/OIG recommendations.

Program Savings

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, the HHS/OIG makes recommendations to agency managers to address these vulnerabilities. In turn, 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. During FY 2008, HHS/OIG reported that legislative and administrative actions to make funds available for better use resulted in an estimated \$16.7 billion in health care savings attributable to FY 2008 -- \$6.7 billion in Medicare savings and \$10 billion in savings to the Federal share of Medicaid. Additional information about savings achieved through such policy and procedural changes may be found in the HHS/OIG Semiannual Report, on-line at <http://oig.hhs.gov/reading/semiannual.html>.

⁹In addition to the funds made available to HHS/OIG from the HCFAC account under HIPAA, Congress also provided funds to HHS/OIG on a temporary basis specifically for oversight of the Medicaid program. The Deficit Reduction Act of 2005 (DRA, P.L. 109-171) appropriated \$25 million to the HHS/OIG for “Medicaid fraud and abuse control activities” for each of fiscal years 2006 through 2010. After FY 2010, that funding will no longer be available. Therefore, HHS/OIG’s FY 2008 Medicaid-related activities cited throughout this report, including the activities discussed below, may draw on funding from both the HCFAC and DRA sources.

Exclusions

One important mechanism for safeguarding the care provided to program beneficiaries is through exclusion of providers and suppliers who have engaged in the abuse or neglect of patients or fraud. During FY 2008, the HHS/OIG excluded a total of 3,129 individuals and entities. Among these were exclusions based on criminal convictions for crimes related to Medicare or Medicaid (692), or to other health care programs (257); for patient abuse or neglect (234); or as a result of licensure revocations, suspensions or surrenders (1,575). This list of conduct is not meant to be exhaustive, but identifies the most prevalent causes underlying HHS/OIG's exclusions of individuals or entities in FY 2008. Among those excluded by HHS/OIG from participation in Medicare, Medicaid, and other Federal health care programs were the following:

- Eight doctors, located throughout the country, were each excluded for the minimum period of 5 years based on their convictions for conspiracy to distribute controlled substances over the Internet. The doctors dispensed, or caused to be dispensed, various controlled substances by means of electronic prescriptions that were issued outside the usual course of medical practice and without a legitimate medical purpose. The doctors were sentenced to various prison or home detention terms, ranging from 8 to 41 months.
- A California anesthesiologist was excluded indefinitely based on the Medical Board of the State of California's revocation of his license to practice medicine. The anesthesiologist's license was revoked based on his unlawful use of controlled substances, gross negligence, repeated negligent acts, incompetence, and unprofessional conduct. It was discovered that over a 4-year period, he frequently used marijuana and cocaine; left the operating room to get food while a patient was under general anesthesia; and made sexual, offensive, and/or inappropriate remarks to staff.
- A California acupuncturist was excluded indefinitely based on the surrender of her license to the State Acupuncture Board for unprofessional conduct and acts involving dishonesty or corruption. The acupuncturist used her acupuncture license as part of a scheme to own and operate a massage parlor where employees solicited for prostitution.
- A caregiver at an Oregon long term care facility for disabled individuals was excluded for a minimum of 25 years based on a conviction for attempting to engage in sexual intercourse with persons incapable of consent by reason of mental defect. The caregiver was sentenced to 303 months of incarceration.

Other Administrative Enforcement Actions – Civil Monetary Penalties

The Office of Inspector General has authority to impose civil monetary penalties (CMPs) against providers and suppliers who knowingly submit false claims to the Government, who participate in unlawful patient referral or kickback schemes, who fail to appropriately treat or refer patients who present at hospital emergency rooms, or who engage in other activities prescribed in statute.

HHS/OIG has continued to pursue its affirmative enforcement actions under these authorities. Examples include:

- Cape Fear Valley Medical Center paid \$42,500 to resolve allegations that it failed to provide an appropriate medical or psychiatric examination for a 13-year-old girl who presented to its emergency department. The girl had reportedly taken a knife to school and threatened to harm herself and others. Without conducting either a medical or psychiatric exam, Cape Fear discharged the girl after a 5-minute meeting with an emergency department physician and provided no discharge instructions. Within the hour, the patient returned to Cape Fear after jumping from a car moving at approximately 40 miles per hour, sustaining a skull fracture, subdural hematoma, possible splenic laceration, and skin abrasions.
- Sparks Health System, Sparks Medical Foundation, and Sparks Regional Medical Center (collectively, Sparks) agreed to pay more than \$1.1 million to resolve allegations, self-disclosed by Sparks, that it billed Medicare for medically unnecessary hospital services and upcoded physician services generated by an internal medicine physician.
- Spartanburg Regional Healthcare System (Spartanburg) agreed to pay \$780,000 to settle its liability under HHS/OIG's CMP authorities for physician referral and anti-kickback violations. Spartanburg disclosed that it provided IT resources to non-employee physician groups without written contracts in place, while failing to bill for the use of those resources.
- America's Health Choice Medical Plans, Inc. (AHC), agreed to pay \$100,000 to resolve allegations that as a participating provider in Medicare Advantage (formerly known as a Medicare+Choice organization), AHC misrepresented information furnished to HHS on at least 10 occasions. Specifically, on at least three occasions, AHC submitted expansion applications that allegedly misrepresented the academic credentials of an AHC employee. In addition, AHC submitted at least seven effectuation notices to the Center for Health Care Dispute Resolution (CHCDR) in which dates of submission were allegedly falsified to appear in compliance with CHCDR's request for claims data.

Studies, Audits, and Evaluations

HHS/OIG conducts numerous studies, audits, and evaluations that disclose questionable or improper conduct in Medicare and Medicaid, and recommends corrective actions that, when implemented, correct program vulnerabilities and save program funds. Among these were:

Medicaid Targeted Case Management Services.

- The Federal Government reimburses the costs of targeted case management (TCM) services, which are services that help Medicaid beneficiaries gain access to needed medical, social, educational, and other services. HHS/OIG issued five reports on States' claims for Medicaid TCM services. HHS/OIG estimated that for FYs 2003 and 2004

Georgia claimed \$4.7 million (\$2.8 million Federal share) in claims for TCM services for individuals deemed at risk of incarceration that were unallowable because, among other reasons, the services were provided to ineligible incarcerated juveniles; that for FYs 2003 and 2004 Iowa improperly claimed \$2.5 million (\$1.5 million Federal share) in costs that were unallowable because they lacked sufficient documentation or were for services that did not meet the definition of TCM services; that for FYs 2002 and 2003 Maine overstated by a total of \$44.2 million (\$29.8 million Federal share) the cost of TCM services provided to recipients of family services because the State did not have procedures for ensuring that Medicaid TCM costs were reasonable, allowable, and allocable, in accordance with Federal requirements; and that for fiscal years 2003 and 2004 Minnesota claimed \$7.3 million (\$3.8 million Federal share) for various services for which the claims did not meet Federal and State documentation requirements. HHS/OIG recommended to these States that they, among taking other steps, refund the questioned costs to the Federal Government. In a fifth report, HHS/OIG estimated that for State FYs 2001 and 2003 Kansas did not ensure that its \$62 million (\$37.2 million Federal share) in TCM claims for recipients of child welfare services was within the limit specified in the State's Medicaid plan. Because the State could not produce the rate and cost data necessary to apply the limit, HHS/OIG was unable to express an opinion on the reasonableness of the claim, and recommended that the State work with CMS to determine the allowability of the \$62 million claimed for the audit period.

Medicaid Disproportionate Hospital Eligibility

- In a study of Indiana's compliance with Medicaid disproportionate share hospital (DSH) payment requirements, HHS/OIG found that from July 2000 through June 2003, the State paid \$142.3 million (\$88.2 million Federal share) to three State-owned psychiatric hospitals that were not eligible to receive DSH payments. States are required to make DSH payments to hospitals that serve disproportionate numbers of low-income patients, but psychiatric hospitals qualify for such payments only if they meet special Medicare conditions of participation. The three hospitals did not meet these conditions. HHS/OIG recommended that the State refund \$88.2 million and ensure that Medicaid DSH payments are made only to eligible hospitals.

Medicaid Drug Costs

- In an audit of the Medicaid drug rebate program, HHS/OIG found that the program could have received \$966 million in additional rebates for the top 200 generic drugs in 1991–2004 had a rebate provision that applies to brand-name drugs been extended to generic drugs. For covered outpatient drugs to be eligible for Federal Medicaid funding, manufacturers must enter into rebate agreements with CMS and pay quarterly rebates to the States. Manufacturers are required to pay an additional rebate when the average manufacturer price for a brand-name drug increases more than a specified inflation factor. There is no similar inflation-based rebate provision for generic drugs. HHS/OIG recommended that CMS consider seeking legislative authority to extend the additional rebate provisions to generic drugs.

- In a study of the impact of unit of measure inconsistencies on Medicaid rebate claims, HHS/OIG identified \$11.8 million in inappropriately claimed Medicaid rebates during the first 6 months of 2006. The method for defining units determines the number of units in a package, or package size; the unit of measure and package size are used together to calculate the per unit reimbursement that Medicaid makes to retail pharmacies and per unit rebate amounts that prescription drug manufacturers pay to States. HHS/OIG recommended that CMS improve its guidance to States regarding detecting and correcting unit of measure inconsistencies.
- In audits of the Medicaid outpatient prescription drug expenditures in two States, HHS/OIG found that both States had claimed Federal Medicaid reimbursement for prescription drug expenditures that did not fully comply with Federal requirements. Medicaid generally covers outpatient drugs if the drug manufacturers have rebate agreements with CMS and pay rebates to the States. For FYs 2004 and 2005, Illinois claimed \$108,000 in unallowable expenditures for prescription drugs that were no longer eligible for reimbursement. The State claimed an additional \$3.5 million for drugs that were not listed on CMS' quarterly tape of covered outpatient drugs. For FYs 2003 and 2004, Missouri claimed \$2.9 million in unallowable expenditures for prescription drugs that were no longer eligible for reimbursement or were inadequately documented. In addition, the State claimed \$1.9 million for drugs that were not listed on the quarterly drug tapes and therefore may not be allowable. In both audits, HHS/OIG recommended that the States refund the questioned costs, and work with CMS to resolve those costs which were identified as potentially unallowable.

Medicaid Home-and-Community-Based Mental Retardation Services

- Based on an audit of Tennessee's claims for home-and community-based services (HCBS) provided to Medicaid beneficiaries with mental retardation and developmental disabilities during State FY 2003, HHS/OIG estimated that the State claimed approximately \$11 million (\$7 million Federal share) for HCBS that were not supported by provider records. HHS/OIG recommended that the State refund the excess Federal reimbursement, establish certain HCBS controls and procedures, and review claims after the audit period and refund any overpayments.

Medicaid School-Based Services

- HHS/OIG found that Utah's claims for Medicaid reimbursement of school-based services provided in FYs 2001–2005 generally did not comply with Federal requirements or the State's Medicaid plan. It was not possible to determine what portion of the \$36.8 million Federal share claimed was allowable as final payments. The State had not, as required by its plan, performed a cost settlement reconciling interim payments to actual costs to determine final payments. HHS/OIG recommended that the State work with CMS to determine the portion of the \$36.8 million that was allowable and to perform cost settlements to ensure that final payments for school-based services are based on actual

costs.

Substance Abuse Treatment Facilities

- In audits of two States' claims for Federal Medicaid reimbursement for services provided in inpatient substance abuse treatment facilities, HHS/OIG found that both States had made improper claims. Federal Medicaid funding generally does not cover substance abuse treatment when it is provided to residents of institutions for mental diseases (IMD) who are between the ages of 22 and 64. From April 2001 through March 2006, New York improperly claimed \$21.5 million in Federal Medicaid reimbursement for services provided to beneficiaries within this age group who resided in IMDs. From January 2002 through December 2006, New Jersey improperly claimed \$1.7 million in Federal Medicaid reimbursement for substance abuse services that were provided to such beneficiaries or to beneficiaries residing in nonparticipating institutional Medicaid facilities or non-accredited psychiatric facilities.

Medicaid Management Information System Expenditures

- In a review of costs claimed by California for operating its Medicaid Management Information System (MMIS) from July 1, 2003, to June 30, 2005, HHS/OIG found that \$2.3 million was improperly claimed, mostly because the costs were not equitably allocated to all benefitting programs, were not related to the Medicaid program, or were claimed twice. An MMIS is a system of software and hardware used to process Medicaid claims and manage information about beneficiaries and services, and its costs are reimbursed by the Federal government at an enhanced rate of 75 percent. HHS/OIG recommended that, among taking other steps, the State refund the improperly claimed costs.

Reconciling Payments to Medicare Part D Sponsors

- In a review of costs claimed by California for operating its Medicaid Management Information System (MMIS) from July 1, 2003, to June 30, 2005, HHS/OIG found that \$2.3 million was improperly claimed, mostly because the costs were not equitably allocated to all benefitting programs, were not related to the Medicaid program, or were claimed twice. In a study of the Medicare Part D preliminary reconciliation data estimates (as of August 2007) and data from 16 sponsors with high enrollments, HHS/OIG estimated that Part D sponsors owed Medicare a net total of \$4.4 billion for the 2006 program year. Eighty percent of the sponsors owed CMS money and 20 percent were due money. HHS/OIG also found that CMS had no mechanism to collect funds or adjust prospective payments prior to the reconciliation that is conducted after the close of the plan year. As a result, sponsors had the use of billions of dollars for a significant length of time. HHS/OIG recommended that, among other steps, CMS ensure that sponsors' bids accurately reflect the cost of providing the benefit to Medicare beneficiaries and that it consider implementing an interim reconciliation process to reduce the amounts owed to Medicare.

Medicare Part D Payments to Local, Community Pharmacies

- In a study of the relationship between Medicare Part D payments to local, community pharmacies and the pharmacies' drug acquisition costs HHS/OIG found that in September 2006, pharmacies almost always (97 percent of the time) acquired drugs for less than the reimbursement amounts. HHS/OIG performed this review at the request of 33 Senators who raised concerns about the sufficiency of reimbursement to local, community pharmacies. HHS/OIG estimated that, excluding dispensing fees and including rebates that drug wholesalers paid to pharmacies, Medicare Part D payments to local, community pharmacies exceeded the pharmacies' drug acquisition costs by 18.1 percent, and recommended that Congress and CMS consider the results of the review in deliberations regarding Medicare Part D reimbursement.

Medicare Part D Beneficiaries' True Out-of-Pocket Costs

- In a review of Medicare Part D plans' tracking of True Out-of-Pocket (TrOOP) costs, HHS/OIG found that in 2006, 29 percent of Part D plans did not, as required, submit their enrollees' additional prescription drug coverage information to Coordination of Benefits Contractors (COBC). Accurate tracking of beneficiaries' TrOOP costs is critical to ensuring appropriate cost sharing under the Part D program. To track TrOOP costs accurately, Part D plans must have information on any prescription drug coverage that enrollees have in addition to Part D coverage. HHS/OIG also found that 34 percent of Part D plans had not submitted prescription drug event data to CMS, 63 percent of the plans cited problems with transferring TrOOP balances when enrollees changed plans, and CMS had conducted limited oversight of Part D plans' tracking of TrOOP costs. HHS/OIG recommendations addressed collecting and submitting data to track costs, increasing the number of COBC agreements, and expanding data collections and oversight authorities.

Marketing Materials for Medicare Part D Drug Plans

- In a review of marketing materials developed by stand-alone Medicare prescription drug plans (PDP) in 2007, HHS/OIG found that CMS provided limited oversight of the materials and that 85 percent of the materials failed to meet at least one element of the agency's guidelines. HHS/OIG found that, among other problems, CMS' model documents were not fully consistent with the agency's own guidelines, which in turn resulted in problems with PDP marketing materials. HHS/OIG recommended that CMS, among other steps, ensure that its model documents are consistent with the guidelines, develop protocols for reviewing marketing materials, and conduct more frequent retrospective reviews of file-and-use materials.

Medicare Part D Contracting

- In a congressionally requested review of contracting issues related to local, community pharmacies' participation in the Medicare Part D program, HHS/OIG found that 78 of the 100 local, community pharmacies in its sample relied on third-party contractors known as pharmacy services administrative organizations (PSAO) to contract with Medicare Part D PDP sponsors. The pharmacies were generally satisfied with the services that their PSAOs provided. The review also found that almost all of the 100 sampled pharmacies and all of their PSAOs reported that they had experienced problems when contracting with PDP sponsors. These problems related to PDP sponsors' network development methods, standard terms and conditions, extended-day supply terms, negotiations, and network requirements and contracting deadlines. HHS/OIG recommended that Congress and CMS consider the results of our review in deliberations about Medicare Part D contracting.

Outpatient Services in Skilled Nursing Facility Stays

- HHS/OIG found that Medicare Part B made a total of \$106.9 million in potential overpayments to suppliers of outpatient hospital, laboratory, and radiology services on behalf of beneficiaries in Part A-covered skilled nursing facilities during CYs 2001 and 2002. These potential overpayments occurred because CMS did not have system edits in place during most of this period. For CY 2003, when the edits were fully implemented, potential overpayments were reduced to \$22.7 million. HHS/OIG estimated that the fiscal intermediaries and carriers had not recovered \$17.9 million of these potential overpayments. HHS/OIG recommended that CMS direct the contractors to review the \$106.9 million in potential overpayments for CYs 2001–2002 and make appropriate recoveries, direct the contractors to initiate recovery of the estimated \$17.9 million in unrecovered overpayments for CY 2003, continue to test and refine the system edits to ensure that they properly identify claims subject to consolidated billing, and ensure that all fiscal intermediaries and carriers have established proper controls to recover overpayments that the system edits identify.

History and Recertification of Medicare Home Health Agencies

- In a review of the deficiency history of more than 5,000 Medicare-certified home health agencies (HHA) as of January 2007, HHS/OIG found that 15 percent of HHAs were cited for the same deficiency on three consecutive surveys and concluded that CMS could improve its oversight of HHAs. HHAs, which provide a range of services to Medicare beneficiaries who are confined to their homes, must meet specific Medicare conditions of participation (CoPs) and health and safety standards. CMS contracts with State agencies to conduct initial HHA certification and recertification surveys of CoP compliance. States cite deficiencies when HHAs are found to be noncompliant with the Medicare CoPs and health and safety standards. HHS/OIG recommended that CMS use existing survey data to identify patterns of deficiency citations and at-risk HHAs and, as directed by Congress in the Omnibus Budget Reconciliation Act of 1987, implement intermediate sanctions against HHAs which are out of compliance with Federal requirements.

Medical Review of Claims in the Comprehensive Error Rate Testing Program

- In a review of CMS' Comprehensive Error Rate Testing (CERT) program, HHS/OIG estimated the error rate in the FY 2006 CERT durable medical equipment (DME) sample to be 17.3 percent or 28.9 percent, depending on the extent of documentation reviewed. CMS established the CERT program to produce a Medicare fee-for-service paid claim error rate, which it reports annually to Congress pursuant to the Improper Payments Act of 2002. HHS/OIG's two-part review, performed by an independent medical review contractor, initially used the same procedures and limited medical records as CMS' CERT contractor and produced an error rate of 17.3 percent. The second part of the review, which used additional medical records from physicians and other health care providers and information from beneficiaries and providers, produced the higher error rate of 28.9 percent. HHS/OIG recommended that CMS require the CERT contractor to review all available supplier documentation and all medical records necessary to determine compliance with applicable requirements on medical necessity and contact the beneficiaries named on high-risk claims to determine whether the DME items were received and were medically necessary.

Medicare Payments for Facet Joint Injection Services

- In a medical review of Medicare payments in 2006 for facet joint injections, which are used to diagnose or treat back pain, HHS/OIG found that 63 percent of facet joint injections service claims allowed did not meet program requirements, resulting in approximately \$96 million in improper payments to physicians and \$33 million in associated facility claims. Among other billing errors, HHS/OIG found that 38 percent of the reviewed claims contained documentation errors, and just over 60 percent of the claims were overpaid because physicians incorrectly billed add-on codes for bilateral injections instead of using the required modifier code. Among other recommendations, HHS/OIG recommended that CMS strengthen program safeguards to prevent improper payment for facet joint services and clarify billing instructions for bilateral services.

DMEPOS Suppliers' Compliance With Medicare Standards in Los Angeles County

- In a review of suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) in Los Angeles County in September and October 2007, HHS/OIG found that 194 of 905 suppliers (22 percent) did not meet one or both of the two Medicare enrollment standards that we selected for review. DMEPOS, which include items such as hospital beds, wheelchairs, respirators, walkers, and artificial limbs, are provided to Medicare beneficiaries by commercial suppliers, that are reimbursed by Medicare. At the time of our review, suppliers had to comply with 21 Medicare DMEPOS enrollment standards. During our unannounced site visits in Los Angeles County, where Medicare allowed \$245 million for these suppliers' claims in the 12-month period beginning July 1, 2006, we found that, among other things, 13 percent of suppliers did not maintain physical facilities or were not open during posted business hours, and that another 9 percent were open but did not post hours of operation or their business names, as required. HHS/OIG recommended that CMS strengthen the Medicare DMEPOS supplier enrollment process

and ensure that suppliers meet Medicare supplier standards.

A Comparison of Medicare Program and Consumer Internet Prices for Power Wheelchairs

- In a review of power wheelchairs, for which Medicare and its beneficiaries spent over \$900 million in 2006, HHS/OIG found that the Medicare fee schedule amounts were 45 percent higher than median Internet prices available to consumers in the first quarter of 2007. Medicare beneficiaries are eligible to receive power wheelchairs under Part B coverage of durable medical equipment. Medicare will pay up to 80 percent of the cost of a power wheelchair, up to the fee schedule amount, and beneficiaries are responsible for paying the remaining amounts. For the period studied during this review, HHS/OIG determined that had suppliers been reimbursed for the same power wheelchairs at median Internet prices, Medicare and its beneficiaries would have spent 28 percent (\$39 million) less than actual payments; on average, each beneficiary could have saved \$233 in a power wheelchair copayment. HHS/OIG recommended that CMS consider performing additional reviews to determine whether current power wheelchair schedule amounts are appropriate.

Medicare Administrative Law Judge Hearings

- In a congressionally requested study of the Office of Medicare Hearings and Appeals' (OMHA) use of telephone, video teleconference, and in-person hearings to decide Medicare cases, HHS/OIG found that in its first 13 months of operation (July 1, 2005, to July 31, 2006), a substantial share of hearings (78 percent) were conducted by telephone. In addition, OMHA's ability to manage its caseload was limited by incomplete and inaccurate data in the appeals system. OMHA did not meet the 90-day decision requirement for 15 percent of the cases with such a requirement and a decision date recorded in the appeals system. HHS/OIG recommended that, among other things, OMHA improve the timeliness of deciding cases with the 90-day decision requirement, and improve the quality of data in the appeals system.

Medicare Contractor Pensions

- Medicare reimburses a portion of the annual contributions that contractors make to their pension plans. HHS/OIG issued three reports examining pension costs claimed by one Medicare contractor. HHS/OIG found that the contractor applied the incorrect accounting principles to a nonqualified pension plan and, as a result, overclaimed \$1.8 million for FYs 1996 to 2004, and that it also overclaimed postretirement benefit costs by \$1.6 million for FYs 2000 to 2004 because it did not compute the costs in accordance with its agreement with CMS. HHS/OIG recommended that the contractor adjust its cost proposals to reduce these overstated costs. In the third report, HHS/OIG found that for FYs 1999 to 2004 the contractor paid executive salaries in excess of the executive compensation limits established in Federal regulations, and recommended that the contractor work with CMS to determine the allowability of \$5.9 million in costs relating to its supplemental executive

retirement plan.

Medicare Payment for Outpatient Services

- HHS/OIG reviewed 45 high-dollar payments (of \$50,000 or more) that a Medicare fiscal intermediary made to hospitals for outpatient services for CYs 2004 and 2005, identifying overpayments totaling more than \$2.7 million that the hospitals had not refunded by the beginning of the audit in May 2007. HHS/OIG found that this fiscal intermediary incorrectly adjusted some claims and that the hospitals reported excessive units of service on other claims. HHS/OIG also found that neither the Fiscal Intermediary Standard System, used to process claims, nor CMS' system had sufficient edits in place during CYs 2004 and 2005 to detect and prevent excessive payments.

Nursing Home “Denial of Medicare Payment” Enforcement Actions

- In its review of denials of payment for new admissions (DPNA), a CMS enforcement action imposed on SNFs that have been found to be noncompliant with Federal program participation standards, HHS/OIG found that in FY 2004 CMS and its fiscal intermediaries (FIs) incorrectly processed 74 percent of such actions, with 40 percent of the DPNA cases resulting in a total of over \$5 million of overpayments to SNFs. CMS is responsible for imposing denial of payment remedies but relies on its FIs to identify and reject the relevant Medicare claims. HHS/OIG identified various processing errors, including CMS not providing the FIs with the instructions on a timely basis or at all, CMS providing information to the wrong FIs, and FIs misinterpreting CMS' instructions. HHS/OIG recommended, among other things, that CMS update guidance on coding readmissions and verifying readmission status for DPNA claims.

Industry Outreach and Guidance

- Advisory Opinions. Central to 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 CMP laws, or the exclusion provisions. During FY 2008, the HHS/OIG, in consultation with DOJ, issued 26 advisory opinions. A total of 192 advisory opinions have been issued during the 12 years of the HCFAC program.
- Corporate and Other Integrity Agreements. Many health care providers that enter agreements with the Government to settle potential liabilities for violations of the FCA also agree to adhere to a separate CIA, Integrity Agreement or other similar agreement. Under these agreements, the provider commits to establishing a program or taking other specified steps to ensure its future compliance with Medicare and Medicaid rules. At the close of FY 2008, HHS/OIG was monitoring compliance with 370 such agreements.
- Supplemental Compliance Program Guidance for Nursing Facilities. HHS/OIG

periodically publishes guidance tailored to specific industry sectors to encourage the development and use of internal controls to monitor adherence to applicable statutes, regulations, and program requirements. HHS/OIG originally published a compliance program guidance (CPG) for nursing facilities in 2000. In FY 2008, HHS/OIG published a supplemental CPG for nursing facilities, building on the original 2000 CPG. The supplemental CPG for nursing facilities, which contains new compliance recommendations and an expanded discussion of risk areas, provides voluntary guidelines to assist nursing facilities in identifying significant risk areas and in evaluating and, as necessary, refining ongoing compliance efforts.

Centers for Medicare & Medicaid Services

In FY 2008, the Centers for Medicare & Medicaid Services (CMS) was allocated approximately \$23 million to fund a variety of projects related to fraud, waste, and abuse in the Medicare and Medicaid programs. CMS has increased its efforts to use advanced technology to detect and prevent fraud and abuse and to ensure that CMS pays the right providers, the right amount, for the right service, on behalf of the right beneficiary. Projects include:

Payment Error Rate Measurement (PERM)

The PERM program was developed to comply with the requirements of the Improper Payments Information Act of 2002 (IPIA), which requires HHS to annually produce national level error rates for Medicaid and the Children's Health Insurance Program (CHIP). CMS elected to use Federal contractors to measure Medicaid and CHIP error rates in a subset of states every year. In FY 2006, CMS measured the fee-for-service component of Medicaid. Starting with FY 2007, PERM was expanded to measure error rates for fee-for-service, managed care, and eligibility in both the Medicaid and CHIP programs. On November 15, 2008 CMS announced for the first time a national composite error rate for Medicaid and CHIP based on the PERM methodology initiated in FY 2006. The baseline error rates, based on FY 2007 claims data, for Medicaid and CHIP are 10.5 percent and 14.7 percent respectively. States participating in the FY 2007 cycles were also provided with their individual error rates. Further evaluation of the error rates shows that the vast majority of Medicaid and CHIP errors were due to inadequate documentation. Providers either did not submit information to the PERM contractor to support their sampled FFS or managed care claims or did not submit additional data as requested. Other errors are due to services provided under Medicaid or CHIP to beneficiaries who were not eligible for either program or who were not eligible for services rendered.

CMS is currently measuring FY 2008 cycle states and has also commenced the FY 2009 cycle. CMS expects the error rates for Medicaid and CHIP will decline in future years through program maturation and, through corrective action initiatives implemented at the state and Federal levels.

Medicaid/Children's Health Insurance Plan (CHIP) Financial Management Project:

Under this project, funding specialists, including accountants and financial analysts, work to improve CMS' financial oversight of the Medicaid and CHIP programs. Through the continued efforts of these specialists, CMS identified and resolved \$2.6 billion of approximately \$8.8 billion in cumulative questionable costs in FY 2008. Furthermore, an estimated \$1.3 billion in questionable reimbursement was actually averted due to the funding specialists' preventive work with states to promote proper state Medicaid financing. The funding specialists activities include reviews of proposed Medicaid state plan amendments that relate to reimbursement; development of financial management reviews; research regarding state Medicaid financing policy and practices; collaboration with states to resolve the Medicaid and CHIP portions of the A-133 "Single State" audits; and identification of sources of the non-Federal share of Medicaid program payments to ensure proper financing of Medicaid program costs.

Administration on Aging

In FY 2008, the Administration on Aging (AoA) was allocated \$3.128 million in HCFAC funds to develop and disseminate consumer education information targeted 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 support 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.

The \$3 million in HCFAC dollars specifically support infrastructure, technical assistance and the other SMP program support and capacity-building activities designed to enhance the effectiveness of state-wide Senior Medicare Patrol programs (SMP) which are funded from a separate Congressional appropriation. These SMP programs recruit retired professionals to educate and assist Medicare beneficiaries to detect and report health care fraud, error, and abuse in the Medicare and Medicaid programs. According to the most recent annual performance report from the Assistant Inspector General for Evaluation and Inspections dated May 9, 2008, over 10,300 active volunteers served the 57 SMP projects during 2007. These volunteers perform an essential function of this program, contributing over 308,000 hours in efforts to share the SMP message of fraud awareness and prevention within the senior community.

Outreach to senior consumers is a key element of the SMP program. During 2007, SMP projects conducted over 13,700 media outreach events and held over 8,400 community education events to increase beneficiary awareness about issues related to Medicare and Medicaid integrity. During this period, almost 131,400 one-on-one counseling sessions were held with or on behalf of a beneficiary on a variety of issues related to potential Medicare or Medicaid fraud, error or abuse. In addition, over 238,500 beneficiaries were educated through group sessions conducted by SMP programs in local communities.

As a result of educating beneficiaries, the projects received close to 70,000 inquiries from or on behalf of beneficiaries and resolved 87 percent of the inquiries in 2007. In addition, SMP projects received over 17,600 complex issues, requiring further research, assistance, case development and/or referral as a result of educational efforts. While the SMP program staff was able to address the majority of these issues for beneficiaries, over 4,000 of these issues, with an estimated dollar value of over \$1.5 million, were referred to law enforcement, CMS integrity contractors, state Medicaid Fraud Control Units, or other entities for further action, and over 5,000 issues were resolved. During this period, over \$7.4 million in healthcare expenditures were avoided as a result of actions taken by the SMP program.

Since the program's inception, SMP projects have educated approximately 3.3 million beneficiaries and received over 104,000 complex issues (complaints) from beneficiaries who have detected billing or other discrepancies based on that information. While it is not possible to directly track all of the cases reported and dollars recovered through SMP community education activities, or quantify the "sentinel effect" in fraud costs avoided due to increased consumer

awareness, over \$105.65 million has been reported as savings attributable to the program as a result of documented complaints since its inception in 1997.

Office of the General Counsel

In FY 2008, The Office of the General Counsel (OGC) was allocated approximately \$5.714 million in HCFAC funding to supplement OGC's efforts to support program integrity activities. OGC provides legal support consistent with the statutory authority of the HCFAC program. While a considerable portion of these funds supported OGC's litigation activity, both administrative and judicial, OGC also continued to focus on program integrity review in 2008.

False Claims Act and Qui Tam Actions: OGC assists DOJ in assessing qui tam actions filed under the FCA by interpreting complex Medicare and Medicaid rules and policies in order to help DOJ focus on those matters which are most likely to result in a recovery of money for the government. When DOJ files or intervenes in a FCA matter, OGC provides litigation support, including interviewing and preparing witnesses and responding to discovery requests. In 2008, OGC participated in FCA and related matters that recovered over \$1.3 billion for the Medicare and Medicaid programs. The types of FCA cases in which OGC participated in 2008 include Medicare Part B drug pricing, off-label pharmaceutical and device promotion, Medicaid drug rebate, physician self-referral and anti-kickback, and upcoding cases.

Provider/Supplier Suspensions and Revocations: OGC assists CMS in deciding whether to suspend payments to Medicare providers and suppliers, or to revoke billing privileges when problems are discovered. During 2008, OGC attorneys were involved in hundreds of suspension and revocation actions involving millions of Medicare dollars and many different segments of the healthcare industry, including DME suppliers, ambulance companies, physicians, infusion clinics, therapists, home health agencies, and diagnostic testing facilities. Some OGC offices experienced dramatic increases in the volume of suspension and revocation work because of satellite CMS offices (in Los Angeles and Miami) which aggressively focused on identifying overpayments and curbing fraud and abuse in problem-prone areas.

Civil Monetary Penalties (CMPs): CMS has the responsibility for administering numerous civil monetary penalty provisions enacted by Congress to enforce program compliance and payment integrity. For example, CMS is authorized to impose CMPs on nursing homes which fail to meet certification standards. During 2008, OGC provided legal advice to CMS regarding the development and imposition of CMPs and defended CMS in administrative appeals and judicial litigation resulting from these cases. OGC recovered or established the right to recover over \$7 million in CMPs during 2008.

CMS is also authorized to impose CMPs on sponsors in the Medicare Part D prescription drug and Medicare Advantage programs. During 2008, OGC defended CMS' imposition of a CMP on a plan sponsor related to allegations of marketing misconduct committed by the sponsor's independent sales agent while selling a Medicare Advantage plan. OGC negotiated a settlement of the matter in which the plan sponsor agreed to pay a CMP of \$190,000 and to engage an independent auditor to review key aspects of its current marketing procedures.

Nursing Home Enforcement: OGC devotes considerable resources to assist CMS in its efforts to assure that nursing home residents receive the high quality of care that the law requires. OGC provides legal advice to CMS regarding the imposition of remedies and defends HHS in administrative hearings when enforcement decisions are challenged. OGC worked very closely with CMS during 2008 to refine its policies with respect to “special focus facilities.” These nursing facilities, which are habitually out of compliance with federal certification requirements, have become the top priority for CMS enforcement efforts as the agency tries to maximize its limited resources to target the nation’s poorest performing nursing homes. As a result of the emphasis on special focus facilities, OGC saw a significant increase in administrative and court proceedings involving terminations of these facilities.

Bankruptcy Litigation: OGC protects Medicare funds by asserting CMS’ recoupment rights to collect overpayments, arguing to continue suspension or termination actions against debtors, seeking adequate assurances from the bankruptcy court that CMS’ interests in the debtor’s estate will be protected, arguing for the assumption of the Medicare provider agreement as an executory contract, and petitioning for administrative costs where appropriate. OGC’s bankruptcy workload continues to be extensive and complex. In 2008, OGC vigorously asserted CMS’ interests in numerous bankruptcy and receivership actions involving hospitals, nursing homes and nursing home chains, negotiated agreements to recover overpayments, and aggressively advanced the use of Medicare’s recoupment authority.

Medicaid Integrity: During 2008, OGC provided wide-ranging legal advice to CMS’ recently-established Medicaid Integrity Group. OGC saw increased involvement in 2008 in Medicaid integrity issues as CMS devoted more resources to financial reviews and oversight, including placing CMS accountants on site at state Medicaid agencies and as states continue to present innovative proposals to reconfigure their programs and to draw down federal financial participation (FFP) at or beyond the margins of the regular Medicaid program. OGC saw a significant increase in the provision of legal advice to CMS regarding proposed disallowances and the filing of Medicaid disallowance appeals before HHS’ Departmental Appeals Board. During 2008, OGC was successful in obtaining decisions upholding millions of dollars in disallowances of FFP.

Regulatory Review and Programmatic Advice: OGC has advised CMS on the management and implementation of its Recovery Audit Contractor (RAC) program. The program, which ran as a demonstration project for 3 years, is now a permanent program pursuant to statute. The mission of the RAC program is to identify Medicare underpayments and overpayments and recoup overpayments for claims submitted under Medicare Parts A and B. CMS is in the process of implementing the permanent RAC program (which must be up and running in all 50 states by January 1, 2010) and OGC has been working with the agency to address questions and concerns raised by the industry about the program.

HIPAA Enforcement: During FY 2008, OGC continued to support HHS’ efforts to promulgate and interpret HIPAA regulations, notably those related to updating and streamlining transaction standards and national provider identifiers. OGC assisted the Department’s enforcement efforts

by investigating and responding to complaints of failures to comply with the HIPAA rules. OGC has also counseled HHS regarding its exercise of enforcement discretion to address recognized industry compliance issues and assisted HHS in expanding the enforcement paradigm by adding a robust compliance review program.

Denial of Claims and Payments: CMS and its contractors engage in various activities and initiatives to detect and prevent abusive and fraudulent billing practices. These measures may include provider and beneficiary education, use of claim sampling techniques and a more rigorous scrutiny of claims with increased medical review. In FY 2008, OGC played a major role in advising CMS regarding the development and implementation of these types of program integrity measures and defended CMS in litigation brought by providers and suppliers who challenge these efforts. OGC continues to aggressively defend CMS and its fiscal intermediaries and carriers in cases seeking damages for the alleged wrongful denial of claims, for being placed on payment suspension, and for not being granted extended repayment plans.

Physician Self-Referral, Electronic Prescribing and Electronic Health Records: OGC worked closely with CMS and HHS in the drafting of proposed rules that are designed to further refine the physician self-referral law and crack down on certain abusive arrangements (including “pod labs” owned by referring physicians). In addition, OGC has worked with CMS and OIG on an advisory opinion and on a new proposed exception to the law aimed at encouraging the donation of technology used to access electronic health information, and promoting gainsharing and other incentive payment and shared savings programs that can increase the quality and cost-effectiveness of health care services.

FUNDING FOR THE DEPARTMENT OF JUSTICE

United States Attorneys

In FY 2008, the United States Attorneys' Offices (USAOs) were allocated approximately \$30.4 million in HCFAC funding to support civil and criminal health care fraud and abuse litigation as exemplified in the Program Accomplishments section. The USAOs dedicated substantial district resources to combating health care fraud and abuse in 2008, and HCFAC allocations have supplemented those resources by providing funding for attorneys, paralegals, auditors and investigators, as well as funds for litigation of resource-intensive health care fraud cases.

The 93 United States Attorneys and their assistants, or AUSAs, are the nation's principal prosecutors of Federal crimes, including health care fraud, and each district has a designated Criminal Health Care Fraud Coordinator and a Civil Health Care Fraud Coordinator. Civil and criminal health care fraud referrals are often made to USAOs through the law enforcement network described herein, and these cases are usually handled primarily by the USAOs, although civil cases are sometimes handled jointly with the Civil Division. The other principal source of referrals of civil cases for USAOs is through the filing of qui tam (or whistleblower) complaints. These cases are often handled jointly with trial attorneys within the Civil Division, but may be handled solely by the USAO. USAOs also handle most criminal and civil appeals at the Federal appellate level.

In addition to the positions funded by HCFAC, the Executive Office for United States Attorneys' Office of Legal Education (OLE) uses HCFAC funds to train AUSAs and other DOJ attorneys, as well as paralegals, investigators, and auditors in the investigation and prosecution of health care fraud. In 2008, OLE offered a Health Care Fraud Seminar for AUSAs and DOJ attorneys, which was attended by over 100 attorneys, as well as, an Affirmative Civil Enforcement Conference, including health care fraud issues, for paralegals, auditors and investigators.

Criminal Prosecutions

In FY 2008, the USAOs received 957 new criminal matters involving 1,641 defendants, and had 1,600 health care fraud criminal matters pending,¹⁰ involving 2,580 defendants. The USAOs filed criminal charges in 502 cases involving 797 defendants, and obtained 588 federal health care fraud related convictions.

Civil Matters and Cases

USAOs play a major role in health care fraud enforcement by bringing affirmative civil cases to recover funds wrongfully taken from the Medicare Trust Fund and other taxpayer-funded health care systems as a result of fraud, waste, and abuse. Civil AUSAs, similar to their criminal counterparts, litigate a wide variety of health care fraud matters including false billings by doctors

¹⁰When a USAO accepts a criminal referral for consideration, the office opens it as a matter pending in the district. A referral remains a pending matter until an indictment or information is filed or it is declined for prosecution.

and other providers of medical services, overcharges by hospitals, Medicaid fraud, kickbacks to induce referrals of Medicare or Medicaid patients, fraud by pharmaceutical companies, and failure of care allegations against nursing home owners.

In FY 2008, USAOs opened 843 new civil health care fraud investigations. At the end of FY 2008, the USAOs had 1311 civil health care fraud investigations pending.

Civil Division

In FY 2008, the Civil Division was allocated approximately \$15.5 million in HCFAC funding to support civil health care fraud litigation (this amount includes \$1 million allotted for the Elder Justice and Nursing Home Initiative). Civil Division attorneys pursue civil and criminal remedies in health care fraud matters, working closely with the USAOs, the FBI, the HHS/OIG 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 Federal Employees Health Benefits Program (FEHB), and other government health care programs.

Civil Division attorneys investigate and litigate a wide range of health care fraud matters. These matters include allegations of overcharging by Part A providers (e.g., hospitals, skilled nursing facilities, hospices), Part B providers and suppliers (e.g., physicians, durable medical equipment manufacturers), and Medicaid providers. These matters also include allegations that providers billed for services that were either not provided or not medically necessary. The Civil Division investigates claims that doctors and others were paid kickbacks or other remuneration to induce referrals of Medicare or Medicaid patients in violation of the Anti-Kickback Act and Physician Self-Referral laws. The Civil Division also investigates a wide range of pharmaceutical and device fraud, including allegations of drug price manipulation and illegal marketing activity that causes the Medicare and Medicaid to pay for drug uses that either were not approved by the FDA or were not supported by medical literature. The Civil Division also investigates claims that skilled nursing facilities bill the Government for care that was so substandard as to be worthless.

In addition to its recovery efforts, the Civil Division remains active in providing training and guidance in connection with pharmaceutical and device fraud matters. Given the nationwide scope of the defendants' conduct, as well as the complex legal and factual issues raised in these cases, the Civil Division plays a critical role in coordinating both investigative efforts and the legal positions taken by the Department. For example, in May 2008, the Commercial Litigation Branch hosted its fourth Pharmaceutical and Device Fraud Conference. This two day conference provided training and guidance to over 100 participants regarding cutting edge issues involving drug and device fraud. The conference was attended by representatives from DOJ, the USAO community, the Food and Drug Administration, the Department of Health and Human Services Office of Inspector General, TRICARE, and the National Association of Medicaid Fraud Control Units.

Lastly, the Elder Justice and Nursing Home Initiative, which is housed within the Civil Division, continues to coordinate and support law enforcement efforts to combat elder abuse, neglect, and

financial exploitation. As the Civil Division does with pharmaceutical fraud cases, the Initiative coordinates and provides guidance on elder abuse cases through the Elder Justice database which is available to DOJ and USAOs, as well as by hosting quarterly teleconferences for attorneys working on failure of care cases to share investigative strategies, discuss recent settlements or regulatory developments, and to identify concerns that may affect attorneys working on these cases. In addition to coordinating law enforcement efforts, the Initiative also makes grants to promote prevention, detection, intervention, investigation and prosecution of elder abuse and neglect, and to improve the scarce forensic knowledge in the field.

Criminal Division

In FY 2008, the Criminal Division was allocated \$3.08 million in HCFAC funding to support criminal health care fraud litigation, prevention and interagency coordination. The Criminal Division's Fraud Section supports the federal white collar crime enforcement community through litigation, coordinating investigations and initiatives, implementing white collar crime policy, and conducting policy and legislative work. The Fraud Section initiates and coordinates complex health care fraud litigation and supports the USAOs with legal and investigative guidance, training, and, in certain instances, provides trial attorneys to prosecute health care fraud cases.

During FY 2008, the Fraud Section, opened or filed 30 new health care fraud cases involving charges against 67 defendants; obtained 69 guilty pleas; and litigated seven jury trials, winning guilty verdicts against eight defendants on all counts charged. Prison sentences imposed in the Section's health care fraud cases during the year averaged more than 40 months, including two sentences that met or exceeded 120 months of imprisonment; and court-ordered restitution, forfeiture and fines that exceeded \$240 million. Fraud Section attorneys staffed and coordinated most of the Division's health care fraud litigation through the Medicare Fraud Strike Force prosecution teams in the Southern District of Florida (Phase One) and in Central District of California (Phase Two).

In Phase Two of the Strike Force, Fraud Section attorneys, working with federal prosecutors from the U.S. Attorneys Office for the Central District of California, and FBI and HHS/OIG agents, executed six search warrants and charged eleven defendants in nine indictments involving more than \$13 million in fraudulent claims to Medicare that were unsealed in May 2008, and arrested another 18 defendants who were charged with submitting more than \$33 million in fraudulent claims to Medicare in eight indictments during a second coordinated arrest round up during September 2008.

Fraud Section attorneys also obtained a guilty plea in the Northern District of Ohio from a physician who defrauded Medicare, Medicaid, and other health care benefit programs by causing medically unnecessary cardiology tests to be administered to patients over an eight-year period, 1998-2006. According to the plea agreement, the physician forfeited approximately \$1.9 million surrendered his medical license, and was permanently excluded from participation in all federal health care programs. In another case, in the Southern District of California, an operator of an unlawful Internet pharmacy pleaded guilty to conspiracy to distribute Schedule II controlled substances, including Oxycontin, Percocet and Endocet, and other prescription drugs, to customers

without prescription or a legitimate medical use. The defendant was not registered with the Drug Enforcement Administration to handle, import, distribute or dispense controlled substances, and shipped the drugs from Southern California to customers throughout the United States. The defendant is awaiting sentencing.

In addition to health care fraud litigation, the Fraud Section also provided legal guidance to FBI and HHS agents, health program agency staff, AUSAs and other Criminal Division attorneys on criminal, civil and administrative tools to combat health care fraud; provided advice and written materials on patient medical record confidentiality and disclosure issues, and coordinated referrals of possible criminal HIPAA privacy violations from the HHS Office for Civil Rights; monitored and coordinated DOJ responses to legislative proposals, major regulatory initiatives, and enforcement policy matters; reviewed and commented on health care provider requests to the HHS/OIG for advisory opinions, and consulted with the HHS/OIG on draft advisory opinions; worked with CMS to improve Medicare contractors' fraud detection, referrals to law enforcement for investigation, and case development work; and prepared and distributed to all USAOs and FBI field office periodic summaries of recent and significant health care fraud cases.

The Criminal Division's Organized Crime and Racketeering Section (OCRS) supports investigations and prosecutions of fraud and abuse targeting the 2.5 million private sector health plans sponsored by employers and/or unions, including schemes by corrupt entities that sell insurance products. Such private sector group health plans are the leading source of health care coverage for individuals not covered by Medicare or Medicaid. OCRS also provides strategic coordination in the identification and prosecution of domestic and international organized crime groups engaged in sophisticated frauds posing a threat to the health care industry.

OCRS provides litigation support and guidance to AUSAs and criminal investigative agencies to combat corruption and abuse of employment based group health plans covered by the Employee Retirement Income Security Act [ERISA]. OCRS attorneys provide health care fraud and abuse training and legal guidance to AUSAs and to criminal investigators and agents of the Department of Labor's Employee Benefits Security Administration and Office of Inspector General. The Section drafts and coordinates criminal legislative initiatives affecting employee health benefit plans and reviews and comments on legislative proposals affecting employee benefit plans.

One OCRS attorney is investigating and prosecuting health care frauds perpetrated by organized criminal groups and is working with the Los Angeles Health Care Fraud Strike Force. In addition, OCRS supports health care fraud prosecutions by Organized Crime Strike Force Units located within various United States Attorneys' Offices. Under the International Organized Crime Initiative commenced in 2008, OCRS monitors trends in the targeting of health care by international organized criminal groups.

Civil Rights Division

In FY 2008, the Civil Rights Division was allocated approximately \$2.37 million in HCFAC funding to support Civil Rights Division litigation activities related to health care fraud and abuse. The Civil Rights Division pursues relief affecting public, residential health care facilities. The Division has also established an initiative to eliminate abuse and grossly substandard care in public, Medicare and Medicaid funded nursing homes and other long-term care facilities. The Division plays a critical role in the HCFAC Program. The Special Litigation Section of the Civil Rights Division is the sole DOJ component responsible for the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997 (CRIPA). CRIPA authorizes the 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 persons who have mental illness, facilities for persons with developmental disabilities, and nursing homes comprises a significant portion of the program. The Special Litigation Section works collaboratively with the USAOs and HHS.

Fiscal Year 2008 Accomplishments

As part of DOJ's Institutional Health Care Abuse and Neglect Initiative, and as an enhancement to ongoing CRIPA enforcement efforts, the Special Litigation Section staff conducted preliminary reviews of conditions and services at 48 health care facilities in 25 states, the District of Columbia, and the Commonwealth of Puerto Rico during Fiscal Year 2008. 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. Separately, in Fiscal Year 2008, the Section opened or continued formal investigations, entered remedial agreements, or monitored existing remedial agreements regarding 67 health care facilities in 23 states, the District of Columbia, the Territory of Guam, and the Commonwealth of Puerto Rico.

In Fiscal Year 2008, the Section commenced investigations of three state-operated facilities for persons with mental illness, 14 state facilities for persons with intellectual and developmental disabilities, and two state veterans nursing homes. The facilities are: Delaware State Psychiatric Hospital, in Newcastle, Delaware; Kings County Hospital Center, in Brooklyn, New York; Ancora Psychiatric Hospital, in Winslow, New Jersey; Denton State School, in Denton, Texas; Abilene State School, in Abilene, Texas; Austin State School in Austin, Texas; Brenham State School, in Brenham, Texas; Corpus Christi State School, in Corpus Christi, Texas; El Paso State Center, in El Paso, Texas; Lufkin State School, in Lufkin, Texas; Mexia State School, in Mexia, Texas; Richmond State School, in Richmond, Texas; Rio Grande State Center, in Harlingen, Texas; San Angelo State School, in Carlsbad, Texas; San Antonio State School, in San Antonio, Texas; Rosewood Center, in Owings Mills, Maryland; Central Virginia Training Center, in Lynchburg, Virginia; William F. Green State Veterans Home, in Bay Minette, Alabama; and

Minnesota Veterans Home, in Minneapolis, Minnesota.

The Section found that conditions and practices at eight state facilities for persons with mental illness, two state facilities for persons with intellectual and developmental disabilities, and three nursing homes violate the residents' Federal constitutional and statutory rights. Those facilities are: Georgia Regional Hospital, in Atlanta, Georgia; Georgia Regional Hospital, in Savannah, Georgia; Northwest Georgia Regional Hospital, in Rome, Georgia; Central State Hospital, in Milledgeville, Georgia; Southwest State Hospital, in Thomasville, Georgia; West Central Georgia Regional Hospital, in Columbus, Georgia; East Central Georgia Regional Hospital, in Augusta, Georgia; Oregon State Hospital, in Salem, Oregon; Beatrice State Developmental Center, in Beatrice, Nebraska; Northwest Habilitation Center, in St. Louis, Missouri; Tennessee State Veterans Homes, in Murfreesboro and Humboldt, Tennessee; and C.M. Tucker Nursing Care Facility, in Columbia, South Carolina.

The Section entered settlement agreements to resolve its investigations of one state-operated facility for persons with intellectual and developmental disabilities, and one state-operated nursing home. Those facilities are: Beatrice State Developmental Center, in Beatrice, Nebraska, and Laguna Honda Hospital and Rehabilitation Center, in San Francisco, California.

The Section continued its investigations of residential facilities for persons with developmental disabilities: Agnews Developmental Center, in San Jose, California; Sonoma Developmental Center, in Eldridge, California; Lanterman Developmental Center, in Pomona, California; Rainier Residential Rehabilitation Center, in Buckley, Washington; Frances Haddon Morgan Center, in Bremerton, Washington; Conway Human Development Center, in Conway, Arkansas; Lubbock State School, in Lubbock, Texas; Bellefontaine Developmental Center, in St. Louis, Missouri; Clyde L. Choate Developmental Center, in Anna, Illinois; and Howe Developmental Center, in Tinley Park, Illinois. The Division also continued its investigation of Oregon State Hospital, in Salem, Oregon, a facility for persons with mental illness. In addition, the Section continued its investigations of three publicly-operated nursing homes: Charlotte Hall Veterans Home, in Charlotte Hall, Maryland; the Laguna Honda Hospital and Rehabilitation Center, in San Francisco, California; and C.M. Tucker Nursing Care Center, in Columbia, South Carolina. In some of these matters, the Section is reviewing voluntary compliance to improve conditions.

The Section monitored the implementation of remedial agreements for 11 facilities for persons with developmental disabilities: Fort Wayne State Developmental Center, in Fort Wayne, Indiana; Clover Bottom Developmental Center, in Nashville, Tennessee; Greene Valley Developmental Center, in Greeneville, Tennessee; Harold Jordan Center, in Nashville, Tennessee; Arlington Developmental Center, in Arlington, Tennessee; New Lisbon Developmental Center, in New Lisbon, New Jersey; Southbury Training School, in Southbury, Connecticut; Woodward Resource Center, in Woodward, Iowa; Glenwood Resource Center, in Glenwood, Iowa; Woodbridge Developmental Center in Woodbridge, New Jersey; and Oakwood Community Center in Somerset, Kentucky. It also monitored the implementation of remedial agreements regarding community placements from facilities for persons with developmental disabilities in Indiana, Puerto Rico, and Washington, D.C.

The Section monitored the implementation of remedial agreements for four nursing homes: Reginald P. White Nursing Facility, in Meridian, Mississippi; Mercer County Geriatric Center, in Trenton, New Jersey; A. Holly Patterson Extended Care Facility in Uniondale, New York; and, Ft. Bayard Medical Center and Nursing Home, in Ft. Bayard, New Mexico. The Section also monitored the implementation of remedial agreements regarding 11 state-operated residential facilities for persons with mental illness: Guam Mental Health Unit in the Territory of Guam; Vermont State Hospital, in Waterbury, Vermont; Dorothea Dix Hospital, in Raleigh, North Carolina; Broughton Hospital, in Morganton, North Carolina; Cherry Hospital, in Goldsboro, North Carolina; John Umstead Hospital, in Butler, North Carolina; Metropolitan State Hospital, in Norwalk, California; Napa State Hospital in Napa, California; Atascadero State Hospital, in Atascadero, California; Patton State Hospital, in Patton, California; and St. Elizabeths Hospital, Washington, D.C.

Finally, the Section monitored the implementation of a remedial agreement regarding one residential facility for children with visual disabilities: New Mexico School for the Visually Handicapped, in Alamogordo, New Mexico.

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 2008, \$120,937,000.”

In FY 2008, the FBI was allocated \$120.9 million in HCFAC funds for health care fraud enforcement. This yearly appropriation was used to support 769 positions (460 Agent, 309 Support) in FY 2008, an increase of 10 positions from the positions supported in FY 2007 (6 Agent, 4 Support). The number of pending investigations has shown steady increase from 591 pending cases in 1992 to 2,434 cases through 2008. FBI-led investigations resulted in 696 criminal health care fraud convictions and 836 indictments and informations being filed in FY 2008.

The FBI is the primary investigative agency involved in the fight against health care fraud that has jurisdiction over both the federal and private insurance programs. With health care expenditures rising at three times the rate of inflation, it is especially important to coordinate all investigative efforts to combat fraud within the health care system. More than \$1 trillion is spent in the private sector on health care and its related services and the FBI's efforts are crucial to the overall success of the program. The FBI leverages its resources in both the private and public arenas through investigative partnerships with agencies such as the HHS/OIG, the FDA, the Drug Enforcement Administration (DEA), the Defense Criminal Investigative Service, the Office of Personnel Management, the Internal Revenue Service and various state and local agencies. On the private side, the FBI is actively involved with national groups, such as the National Health Care Anti-Fraud Association (NHCAA), the Blue Cross and Blue Shield Association and the National Insurance Crime Bureau, as well as many other professional and fundamental efforts to expose and investigate fraud within the system.

Health care fraud investigations are considered a priority within the White Collar Crime Program Plan. In addition to being a partner in the majority of investigations listed in the body of this report, FBI field offices throughout the U.S. have pro-actively addressed significant health care fraud through coordinated initiatives, task forces, and undercover operations to identify and pursue investigations against the most egregious offenders which may include organized criminal activity and criminal enterprises. Organized criminal activity has been identified in the operation of medical clinics, independent diagnostic testing facilities, durable medical equipment companies and other health care facilities. The FBI is committed to addressing this criminal activity through disruption, dismantlement and prosecution of criminal organizations.

The FBI initiated the Internet Pharmacy Fraud Initiative which focuses on Internet web sites and

individuals selling illegal prescription drugs and controlled substances. The overall goal of the Internet Pharmacy Fraud Initiative is to identify fraudulent Internet pharmacies and target physicians who are willing to write prescriptions for financial gain outside of the doctor/patient relationship and with no legitimate medical purpose. Also in the scope of this initiative are investigations involving the sale of counterfeit and diverted pharmaceuticals on the Internet.

During FY 2008 the FBI continued its support of the South Florida Medicare Strike Force (SFMSF) which was initiated to combat the prodigious Medicare fraud problem endemic to South Florida. Its mission was to adapt the traditional investigative and prosecutorial methodology to more appropriately address the contemporary way in which Medicare fraud is committed. The Strike Force was a concerted effort from the Department of Justice, the United States Attorney's Office in the Southern District of Florida, the FBI, HHS/OIG, the Florida Medicaid Fraud Control Unit, and the Hialeah Police Department.

In addition in FY 2008 the FBI fully supported the DOJ-led Medicare Strike Forces (MSF) deployment to Southern California, specifically Los Angeles. The task force in Los Angeles is similar in composition to the SFMSF with contributing agencies being the United States Attorney's office, Central District of California, the Internal Revenue Service – Criminal Investigative, HHS/OIG, the Los Angeles Police Department and other state and local agencies. In FY 2009 the FBI will continue to support the MSF and will work closely with the DOJ as this strike force concept is expanded to other areas of the country.

The FBI has also initiated a new and aggressive training program. The FBI realizes that the most important resource for the successful investigation of health care fraud violations is that of human capital. Therefore, in FY 2008, as in FY 2007 and continuing the FBI will continue its aggressive training curriculum to include expanding the ability of those who investigate health care fraud matters to attend additional training sponsored by private entities such as the NHCAA. In addition, the FBI is revamping its virtual academy training sites to include specific blocks related directly to health care fraud investigations.

The majority of funding received by the FBI is used to pay personnel costs associated with the 769 funded positions. Funds not used directly for personnel matters are used to provide operational support for major health care fraud investigations and national initiatives currently focusing on Internet Pharmacy fraud, Training and the DOJ Strike Force. Further, the FBI continues to support individual investigative needs such as the purchase of specialized equipment and expert witness testimony on an as-needed basis.

Glossary Of Terms

The Account - The Health Care Fraud and Abuse Control Account

AoA - Department of Health and Human Services, Administration on Aging

AUSA - Assistant United States Attorney

CERT - Comprehensive Error Rate Testing

CHIP - Children's Health Insurance Plan

CIA - Corporate Integrity Agreement

CMP - Civil Monetary Penalty

CMPL - Civil Monetary Penalties Law, 42 U.S.C. § 1320a-7a

CMS - Department of Health and Human Services, Centers for Medicare & Medicaid Services

COBC - Coordination of Benefits Contractors

CoP - Conditions of Participation

CPG - Compliance Program Guidance

CRIPA - Civil Rights of Institutionalized Persons Act

CY - Calendar Year

DAB-Department of Health and Human Services, Departmental Appeals Board

DEA - Drug Enforcement Administration

DME - Durable Medical Equipment

DMEPOS - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

DPNA - Denials of Payment for New Admissions

DRA - Deficit Reduction Act of 2005

DOJ - The Department of Justice

DSH - Disproportionate Share Hospital

EOUSA - Executive Office for the United States Attorneys

FBI - Federal Bureau of Investigation

FCA - False Claims Act

FDA - Food and Drug Administration

FEHBP - Federal Employees Health Benefits Program

FFP - Federal Financial Participation

FFS - Fee for Service

FI - Fiscal Intermediary

FTE-Full-time equivalent

HCFAC - Health Care Fraud and Abuse Control Program or the Program

HHa - Home Health Agencies

HHS - The Department of Health and Human Services

HHS/OIG - The Department of Health and Human Services - Office of the Inspector General

HI - Hospital Insurance Trust Fund

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

HIV - Human Immunodeficiency Virus

HRSA - The Department of Health and Humans Services - Health Resources and Services Administration

IPIA - Improper Payments Information Act of 2002, P.L. 107-300

MA - Medicare Advantage plan

MSF - Medicare Strike Force

MFSF - Medicare Fraud Strike Force

MMA - Medicare Prescription Drug, Improvement and Modernization Act of 2003

MMIS - Medicaid Management Information System

NHCAA - National Health Care Anti-Fraud Association

OCRS- Organized Crime and Racketeering Section-Department of Justice Criminal Division

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

OMHA - Off-ice of Medicare Hearings and Appeals

PERM - Program Error Rate Measurement

The Program - The Health Care Fraud and Abuse Control Program

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

SFMSF - South Florida Medicare Strike Force

SMP - Senior Medicare Patrol

SNF - Skilled Nursing Facility

TCM - Targeted Case Management

TrOOP - True Out-of-Pocket costs

USAO - United States Attorney's Office