
**The Department of Health and Human Services
And
The Department of Justice
Health Care Fraud and Abuse Control Program
Annual Report For FY 1997**

January 1998

FOREWORD

Fraud in the United States' health care system is a serious problem that has an impact on all health care payers, and indeed affects every person in this country. Dollars alone do not fully measure the impact of health care fraud on our Nation. Fraudulent billing practices may also disguise inadequate or improper treatment for patients.

The Department of Health and Human Services and the Department of Justice, along with other federal, state and local agencies, are committed to aggressive efforts to enforce the law and prevent health care fraud. On-going efforts to attack fraud and abuse in federal health programs were consolidated and strengthened under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA provided powerful new criminal and civil enforcement tools as well as expanded resources for the fight against health care fraud.

This first annual report of the Health Care Fraud and Abuse Control Program under HIPAA shows that we are making dramatic new headway. During 1997, the first full year of anti-fraud and abuse funding under HIPAA, we have recorded the most successful year ever in the nation's efforts to detect and punish fraud and abuse against federal health programs, in particular the Medicare and Medicaid programs. Not only are collections and enforcement actions at an all-time high, but much greater amounts are being returned to the Medicare Trust Fund. During 1997:

- \$1.087 billion was collected in criminal fines, civil judgments and settlements, and administrative impositions.
- \$968 million was returned to the Medicare Trust Fund, and \$31 million was recovered as the federal share of Medicaid restitution.
- More than 2,700 individuals and entities were excluded from federally sponsored health care programs — a 93 percent increase over 1996.
- Federal prosecutors opened 4,010 civil health care matters, an increase of 61 percent over 1996.

The success of this Program comes from the hard work done on a day-to-day basis by dedicated investigators, auditors, prosecutors, and support personnel across this Nation. As we highlight their contributions in this report, we must also aim at bringing about even greater participation by patients and honest health care providers in identifying and reporting fraudulent and abusive practices. Ultimately our success against fraud and abuse in health care rests on an attitude of "zero-tolerance" for fraud throughout our health care system.

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GENERAL NOTE

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

EXECUTIVE SUMMARY

Many forms of health care fraud and abuse pose a threat to the health and safety of countless Americans, including many of the most vulnerable members of our society. To respond to this serious problem, Congress passed, and the President signed into law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). HIPAA provided powerful new criminal and civil enforcement tools and \$104 million in resources in 1997 dedicated to the fight against health care fraud. (Separately, the Federal Bureau of Investigation (FBI) received \$47 million which is discussed in the Appendix to this report.) In addition, HIPAA required the Attorney General and the Secretary of the Department of Health and Human Services (HHS), acting through the Inspector General, to establish a coordinated national Health Care Fraud and Abuse Control Program ("Program"). The Program provides a coordinated national framework for federal, state, and local law enforcement agencies, the private sector, and the public to fight health care fraud.

The first-year results of the Program demonstrate its effectiveness in meeting the goals established by Congress in HIPAA.

Civil and Criminal Enforcement Actions

Civil and criminal health care fraud enforcement actions increased significantly in 1997. Federal prosecutors filed 282 criminal indictments in health care fraud cases in 1997 -- a 15 percent increase over the previous year. Similarly, the number of defendants convicted for health care fraud-related crimes rose from 307 in 1996 to 363 in 1997 -- an 18 percent increase. The number of civil health care matters also increased in 1997, with federal prosecutors opening 4,010 civil matters -- an increase of 61 percent over 1996.

Monetary Results

In 1997, the Federal Government won or negotiated more than \$1.2 billion in judgments, settlements, and administrative impositions in health care fraud cases and proceedings. As a result of these activities, as well as prior year judgments, settlements, and administrative impositions, the Federal Government in 1997 collected \$1.087 billion. It should be noted that some of the judgments, settlements, and administrative impositions in 1997 will result in collections in future years, just as some of the collections in 1997 are attributable to actions from prior years.

A significant portion of the \$1.087 billion collected was the result of nationwide investigations into fraudulent billing practices of hospitals and independent laboratories. More than 89 percent (\$968 million) of the funds collected and disbursed in 1997 were returned to the Medicare Trust Fund. An additional \$31 million was recovered as the Federal share of Medicaid restitution.

In addition, 326 Medicare coverage reviews were made in 19 states and overpayments in the amount of \$87.6 million were identified. HCFA is in the process of collecting these overpayments.

Exclusion from Federally Sponsored Programs

HIPAA provided powerful new tools to prohibit companies or individuals convicted of certain health care offenses from participating in Medicare, Medicaid or other federally sponsored health care programs. In 1997, HHS excluded more than 2,700 individuals and entities from federally sponsored health care programs -- a 93 percent increase over 1996.

Preventing Health Care Fraud

Preventing health care fraud and abuse is a central component of the Program. The Program's prevention efforts include the promulgation of formal advisory opinions to industry on proposed business practices, model compliance plans, special fraud alerts, and beneficiary and provider education and outreach.

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 1997**

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

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

- (A) the amounts appropriated to the Federal Hospital Insurance (HI) Trust Fund for the previous fiscal year under various categories and the source of such amounts; and
- (B) the amounts appropriated from the Trust Fund for such year for use by the Attorney General and the Secretary and the justification for the expenditure of such amounts.

This 1997 Annual Report thus discusses those funds which HHS and DOJ are required to deposit in the HI Trust Fund, and those funds which HIPAA appropriated from the HI Trust Fund.

The Act requires that an amount equaling recoveries from health care investigations -- including criminal fines, forfeitures, and civil and administrative penalties and judgments, but excluding restitution, compensation and relators' awards -- shall be deposited in the HI Trust Fund. All funds deposited in the Trust Fund as a result of the Act are available for the operations of the Trust Fund.

As stated above, the Act appropriated monies from the HI Trust Fund to a newly created expenditure account, called the Health Care Fraud and Abuse Control Account (the Account), in amounts that the Secretary and Attorney General jointly certify are necessary to finance anti-fraud activities. The maximum amounts available for expenditure are specified in the Act. Certain of these sums are to be available only for activities of the Office of Inspector General (OIG) of HHS, with respect to Medicare and Medicaid programs. To the extent that the remaining funds are not spent directly by HHS and the Department of Justice (DOJ) on establishment and operation of the Program, funds may be made available to other federal, state and local health care enforcement

organizations for purposes that further the Program. In the first year of operation of the Program, 1997, the Secretary and the Attorney General certified \$104 million for appropriation to the Account. A detailed breakdown of the allocation of these funds is set forth later in this report. These resources supplement the direct appropriations of HHS and DOJ that are devoted to health care fraud enforcement. (Separately, the FBI received \$47 million from HIPAA which is discussed in the Appendix.)

Under the joint direction of the Attorney General and the Secretary of Health and Human Services (HHS) acting through the Department's Inspector General, the Program's goals are:

- (1) to coordinate federal, state and local law enforcement efforts relating to health care fraud and abuse;
- (2) to conduct investigations, audits, and evaluations relating to the delivery of and payment for health care in the United States;
- (3) to facilitate enforcement of all applicable remedies for such fraud;
- (4) to provide guidance to the health care industry regarding fraudulent practices; and
- (5) to establish a national data bank to receive and report final adverse actions against health care providers.

HHS and DOJ Activities in 1997

HIPAA, signed into law in August 1996, contained an aggressive timetable for implementation of the fraud and abuse control provisions of Title II. Funding under the Act began with 1997, with the Program and implementing guidelines to be in place no later than January 1, 1997. The overall Program required rapid initiation of a host of actions, including issuance of regulations (such as those governing a new process for issuing advisory opinions to the public on fraudulent health care transactions), initiation of negotiated rulemaking on anti-kickback penalties in the context of risk sharing arrangements, and initiation of a beneficiary incentive and outreach program. To make the most effective use of the tools and resources provided under HIPAA, HHS and DOJ, along with other federal, state and local agencies are joined in a coordinated national health care fraud enforcement and prevention program.

This collaborative effort resulted in numerous accomplishments, including the following achievements:

- In November 1996, HHS and DOJ signed a Memorandum of Understanding that set out procedures for the establishment of the Account, allocation of funds under the Program, expenditures of Account funds and accounting for such funds, tracking of recoveries under the Program, and overall evaluation of the Program.

- In January 1997, the Attorney General and the Secretary issued guidelines that provide a coordinated framework for enforcement and prevention efforts. The guidelines incorporated input from the law enforcement agencies charged with combating health care fraud.
- Civil and criminal health care fraud enforcement actions increased significantly in 1997. Federal prosecutors filed 282 criminal indictments in health care fraud cases in 1997 -- a 15 percent increase over the previous year. Similarly, the number of defendants convicted for health care fraud-related crimes rose from 307 in 1996 to 363 in 1997 -- an 18 percent increase. The number of civil health care matters also increased in 1997, with federal prosecutors opening 4,010 civil matters -- an increase of 61 percent over 1996.
- In 1997, the Federal Government won or negotiated more than \$1.2 billion in judgments, settlements, and administrative impositions in health care fraud cases and proceedings. As a result of these activities, as well as prior year judgments, settlements, and administrative impositions, the Federal Government in 1997 collected \$1.087 billion. It should be noted that some of the judgments, settlements, and administrative impositions in 1997 will result in collections in future years, just as some of the collections in 1997 are attributable to action from prior years. A portion of the judgments, settlements, and administrative impositions reflected here are the culmination of investigations and prosecutions begun before the effective date of the Program. Thus, resolution of these enforcement activities is not attributable solely to funding under the new Program. At the same time, many enforcement actions undertaken in 1997 will not result in collections until future years.
- 326 Medicare coverage reviews were made in 19 states and overpayments in the amount of \$87.6 million were identified. HCFA is in the process of collecting these overpayments.
- More than 2,700 individuals and entities were excluded from participation in Medicare, Medicaid and other Federal and state health care programs, due to their inappropriate activities -- a 93 percent increase over 1996.
- Many diverse initiatives were aimed at prevention of health care fraud and abuse, among them: (1) procedures for requesting and issuing formal advisory opinions were developed, and the first four opinions were issued; (2) HHS canvassed the health care industry and received suggestions on general issues in which industry guidance, in the form of safe harbors or special fraud alerts, was needed; (3) HHS and DOJ convened negotiated rulemaking on the issue of kickbacks in shared risk arrangements; (4) a model compliance plan for the clinical laboratory industry was issued; (5) HCFA, the Administration on Aging and the HHS/OIG joined with the private sector to survey beneficiary populations to assist in devising an effective outreach to educate the elderly to recognize and report fraud; (6) a total of 84 corporate integrity agreements were entered with parties in connection with fraud settlements.

- Of the funds made available for 1997, \$1.55 million was given to Federal, state and local agencies (other than HHS and DOJ) that are currently involved in health care fraud and abuse activities. In future months, these groups will be monitored for effectiveness in furthering the goals of the Program. These grants are described on page 29.

The remainder of this report provides a more detailed look at these and other accomplishments under the Program, and statistical data summarizing disbursement of collections and expenditures during the first year of its operation.

MONETARY RESULTS

As required by the Act, HHS and DOJ must detail in this Annual Report the amounts deposited and appropriated to the HI Trust Fund, and the source of such deposits. In 1997, the combined anti-fraud actions of the federal and state governments and numerous private citizens produced remarkable outcomes with respect to collections as the result of successful investigations, negotiations and lawsuits. The Federal Government collected \$1.087 billion in connection with health care fraud cases and matters in 1997¹. These funds were deposited with the Department of the Treasury and HCFA, transferred to other federal agencies administering health care programs, or paid to private persons. The following chart provides a breakdown of the transfers/deposits:

Total Transfer/Deposits by Recipient 1997	
Department of the Treasury	
HIPAA Deposits to the HI Trust Fund	\$6,750
Gifts and Bequests	46,162,414
Amount Equal to Criminal Fines*	732,577
Civil Monetary Penalties	0
Amount Equal to Asset Forfeiture **	88,828,469
Amount Equal to Penalties and Multiple Damages	
Health Care Financing Administration	
OIG Audit Disallowances - Recovered	302,288,607
Restitution/Compensatory Damages	<u>560,576,678</u>
	998,595,495
Restitution/Compensatory Damages to Other Federal Agencies	
Department of Veterans Affairs	22,131,850
National Institutes of Health	13,513,956
Office of Personnel Management	6,465,074
Department of Defense	6,334,917
Railroad Retirement Board	4,810,169
Other	<u>2,276,621</u>
	55,532,587
Relators' Payments ***	33,169,932
TOTAL ****	\$1,087,298,014

*Reports to the Department of the Treasury were overstated by \$5,000,000 in 1997. A correction will be reflected in the 1998 HCFAC Annual Report.

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

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

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

¹In 1997, DOJ collected an additional \$136,800,000 in health care fraud cases and matters that was not disbursed to the affected agencies and/or the Account in 1997 due to: (i) on-going litigation regarding relator shares in qui tam cases that will affect the amount retained by the Federal Government; (ii) receipt of funds late in the year that were then processed in 1998; and (iii) delays in recoding collections originally directed into miscellaneous Treasury receipts. Of this total, \$79,767,000 is still in suspense pending outcome of litigation; approximately \$40,893,000 has been disbursed in 1998 to the appropriate agencies and the Account; and \$16,140,000 is expected to be so disbursed later in 1998.

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

- (1) Gifts and bequests made unconditionally to the Trust Fund, for the benefit of the Account or any activity financed through the Account.
- (2) Criminal fines recovered in cases involving a federal health care offense, including collections under 1347 of title 18, U.S.C. (relating to health care fraud);
- (3) Civil monetary penalties in cases involving a federal health care offense;
- (4) Amounts resulting from the forfeiture of property by reason of a federal health care offense, including collections under section 982(a)(6) of title 18, U.S.C.;
- (5) Penalties and damages obtained and otherwise creditable to miscellaneous receipts of the general fund of the Treasury obtained under sections 3729 through 3733 Title 31, United States Code (known as the False Claims Act), in cases involving claims related to the provision of health care items and services (other than funds awarded to a relator, for restitution or otherwise authorized by law).

HIPAA requires an independent review of these deposits by the General Accounting Office (GAO). The GAO report is to be submitted to Congress by June 1, 1998.

EXPENDITURES

In the first year of operation, the Secretary and the Attorney General certified \$104 million as necessary for the Program. The following chart gives the allocation by recipient:

1997 ALLOCATION OF HCFAC APPROPRIATION (Dollars in thousands)	
Organization	Allocation
Department of Health and Human Services	
Office of Inspector General	\$70,000
Health Care Financing Administration	5,346
Health Resources and Services Administration	2,000
Office of the General Counsel	1,800
Administration on Aging	<u>1,100</u>
Total	\$80,246
Department of Justice	
United States Attorneys	\$8,548
Civil Division	9,656
Federal Bureau of Investigation	3,625
Criminal Division	329
Justice Management Division	<u>42</u>
Total	\$22,200
Other Agencies	\$1,554
Total	\$104,000

These resources supplement the direct appropriations of HHS and DOJ that are devoted to health care fraud enforcement.

Overview of Accomplishments

The Act centralizes coordination of all public and private health care fraud enforcement activities in a single program, led by HHS and DOJ, working in conjunction with: State Medicaid Fraud Control Units (MFCUs); Department of Defense (DOD), Defense Criminal Investigative Service (DCIS)(Civilian Health and Medical Program of the Uniformed Services - CHAMPUS, also called TRICARE); the United States Postal Service; the Internal Revenue Service; the Drug Enforcement Administration; the Office of Personnel Management (OPM), Office of Inspector General (Federal Employees Health Benefits Plan); Department of Veteran Affairs (VA), Office of Inspector General; the Food and Drug Administration; and the Department of Labor (DOL).

The Congress and the President recognized that close coordination among federal, state and local law enforcement agencies, as well as private insurers and health plans, is crucial to successfully detect, prosecute and prevent fraud in the vast health care industry.

Recent experience confirms the benefits of enhanced coordination. A two-year demonstration project, Operation Restore Trust (ORT), illustrated that extensive collaboration among law enforcement agencies would result in greater effectiveness and efficiency in preventing and detecting fraud and abuse in certain targeted services reimbursed by Medicare and Medicaid. Such coordination among government, industry, and the beneficiary population thus forms the essential foundation of the HCFAC Program.

HIPAA's landmark reforms bring critically needed resources and stronger enforcement tools to the battle against health care fraud and abuse. As envisioned by HIPAA, we have continued the successful partnerships forged earlier, expanding their membership and scope as necessary to address fraud and abuse throughout the health care industry. Nationally, the Executive Level Health Care Fraud Policy Group (composed of HHS/OIG, HCFA, HHS Office of General Counsel (OGC), FBI, and DOJ civil and criminal prosecutors), the National Health Care Fraud Working Group (composed of HHS, DOJ, DOD, DOL, VA, Department of the Treasury, OPM, United States Railroad Retirement Board, United States Postal Service, and the National Association of Attorneys General) and other bodies share information on both specific cases and overall trends. This national coordination is increasingly vital to curbing national schemes that cut across state lines and enforcement jurisdictions.

These national groups also sponsor training to enforcement personnel on detecting and prosecuting complex health care schemes. For example, the HHS/OIG and the FBI are together sponsoring four interagency training sessions regarding health care fraud and abuse. Building on the partnerships forged by the ORT demonstration project, the training is designed to further enhance agencies' understanding of the complexities of the federal health care programs. The focus areas of the training are: managed care (held in September 1997); durable medical equipment (held in December 1997); ambulance payments (to be held in 1998); and home health care (to be held in 1998). HHS/OIG also held an advanced training seminar for agents who have been with the HHS/OIG for two years or less. Held in September 1997, the advanced seminar focused on emerging issues. The next seminar is planned for April 1998. In addition, HCFA has provided training sessions on basic Medicare and Medicaid program issues. Developed by HCFA in collaboration with the HHS/OIG and FBI, this training enabled new agents and investigators to understand Medicare and Medicaid program policies and operation, and was conducted on a regional basis during 1997 and the first quarter of 1998. This training will also be provided to DOJ attorneys in 1998.

At the local level, more and more health care fraud working groups and task forces are getting underway. These working groups encourage communication and coordination among law enforcement officials in sharing information on specific cases, and selecting appropriate remedies. Local working groups have been encouraged to establish a liaison with licensing and

regulatory bodies, state officials, and private insurers. Task forces have also reached out to consumer and provider groups, so as to work together to identify fraudulent health care schemes, and to encourage referral of such information to the appropriate officials.

During this year, the Federal Government won or negotiated more than \$1.2 billion in judgments, settlements, and administrative impositions in health care fraud cases and proceedings. As a result of these activities, as well as prior year judgments, settlements, and administrative impositions, the Federal Government in 1997 collected \$1.087 billion in cases resulting from health care fraud and abuse, of which \$968 million was returned to the Medicare Trust Fund and \$31 million was recovered as the federal share of Medicaid restitution. These unprecedented figures are attributable, in large part, to the ongoing and expanded collaboration among health care oversight and enforcement officials at all levels of government and the private sector. It should be noted that some of the judgments, settlements, and administrative impositions in 1997 will result in collections in future years, just as some of the collections in 1997 are attributable to actions from prior years.

Working together, we have brought to successful conclusion the investigation and prosecution of some of the most far reaching and costly health care fraud schemes including:

- Independent Clinical Laboratories: During 1997, the Federal Government achieved significant successes in its three-year task force effort targeting unbundling schemes whereby the nation's three largest independent clinical laboratories routinely billed Medicare for medically unnecessary tests, and for tests that the physician never ordered. The three laboratories agreed to pay a total of \$642 million to settle potential civil and or criminal liability to the federal and state governments. The Federal Government also required each corporation to enter a corporate integrity agreement to help safeguard against future fraud in laboratory billing practices.
- Diagnosis Related Groups (DRG) 72 Hour Window Project: A series of audits conducted by HHS/OIG disclosed that many hospitals were improperly billing Medicare for outpatient services rendered within 72 hours prior to and during a hospital admission, in addition to billing for the set fee (the DRG) Medicare pays for each admission (which is supposed to include the outpatient services rendered within 72 hours prior to the admission). In response, HHS/OIG and DOJ launched a national initiative to recover these duplicate payments, and to compel hospitals to institute corrective measures to prevent such improper claims in the future. As of October 1, 1997, more than \$46 million has been returned to the Federal Government.

A more detailed description of the accomplishments of the major federal participants in the coordinated effort established under HIPAA follows. While information in this report is presented in the context of a single agency, most of these accomplishments reflect the combined efforts of HHS, DOJ and other partners in the anti-fraud efforts. After just one year of operation under the program, the successes of the Departments of Justice and HHS and our partners in the coordinated anti-fraud effort already amply confirm that the increased funds to battle health care fraud and abuse were wisely invested.

FUNDING FOR DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General

HIPAA mandates that the HHS/OIG receive a certain sum of money, within a stipulated range, for Medicare and Medicaid activities. During the first year of the Program, the Secretary and the Attorney General jointly allotted to these efforts the maximum statutory amount authorized: \$70 million. This represents an estimated \$27 million increase in available funds for the HHS/OIG to combat fraud in HHS-funded health care programs.

HHS/OIG was involved in more than 1,400 successful prosecutions and/or settlements in 1997. More than 2,700 individuals and entities were excluded from doing business with Medicare, Medicaid and other federal and state health care programs as a result largely of criminal convictions (1101), licensure revocations (588), or other professional misconduct (1030) -- a 93 percent increase from the 1,400 exclusions in 1996. In addition to its role in bringing about the judgments and settlements described in the Executive Summary, HHS/OIG recommended and the Department disallowed \$84.5 million in improperly paid health care funds in 1997. HHS/OIG efforts also resulted in health care funds not expended (i.e. funds put to better use as a result of implemented HHS/OIG recommendations and other initiatives) of approximately \$6.1 billion for 1997.

These early successes are attributable, in part, to the additional staff and resources made available under HIPAA. During 1997, HHS/OIG staff levels increased from a little over 900 to 1,143 by the end of the year. In addition, HHS/OIG opened six new investigative offices and three new audit offices. Six more investigative offices will be opened during 1998. The staff of the HHS/OIG Office of Evaluation and Inspections has also increased, thereby strengthening the office's ability to conduct short term national evaluations that provide policymakers and managers with analysis and recommendations for improving the effectiveness and efficiency of HHS programs. The outcomes of these inspections can lead to increased cost savings, improved quality of care or services, improved program efficiency and the identification of program vulnerabilities. Overall, new staff has enabled the HHS/OIG to intensify and expand its activities in the health care field and to coordinate a more effective effort to curb Medicare and Medicaid fraud and abuse.

The additional resources and authorities granted by HIPAA have supported numerous important HHS/OIG projects. For example, HHS/OIG investigators and auditors have been instrumental participants in the marked success of many coordinated national initiatives, some of which are

referenced above. In addition, HHS/OIG investigations and audits have supported numerous other significant criminal convictions and civil settlements in a number of different arenas in the health care industry that resulted in returns to the Trust Fund in 1997:

- **Home Health Agency Fraud:** First American Home Health Care of Georgia, formerly ABC Home Health Services, entered an agreement in settlement of charges that they filed false cost reports to Medicare; cost reports that included ghost employees, personal expenses, and political contributions, under which the owners agreed to pay the Federal Government \$255 million. This represents the culmination of an investigation that was ongoing for seven years.
- **Durable Medical Equipment - Incontinence Care Kits:** As part of the HHS/OIG's continued pursuit of fraud in the durable medical equipment industry, the HHS/OIG investigated one of the largest billers of Medicare for incontinence care products. The owner of this supply company was sentenced to 10 years imprisonment for billing Medicare for female incontinence care kits provided to nursing home patients, when he actually provided only adult diapers.
- **Administration of the Medicare Program:** After a two-year investigation, a former Medicare carrier, Blue Shield of California, agreed to pay \$12 million in settlement of its civil liability for having falsified its claims processing data and capabilities. The company also pled guilty to conspiracy, and obstruction of a federal audit, and was fined an additional \$1.5 million.

Audits

Audit efforts are increasingly central to the detection of fraud against and vulnerabilities in health care programs. Foremost among these efforts is the audit of HCFA's financial statements. Initially mandated by the Chief Financial Officers Act, and expanded by the Government Management Reform Act of 1994, these annual financial statement audits provide an objective evaluation of the reliability of those statements and, importantly, include an evaluation of financial management processes, systems and internal controls. As part of this review, and for the first time in the history of the Medicare program, a comprehensive, statistically valid sample of fee-for-service claims was taken to determine the correctness of Medicare payments. The audit, jointly funded by HHS/OIG and HCFA, revealed estimated improper Medicare payments of approximately \$23 billion, or about 14 percent of total Medicare fee-for-service benefit payments made during the year. Most of the improper payments were attributable to insufficient or no documentation, lack of medical necessity, incorrect coding, and unallowable services. The audit did not determine what portion of these improper payments are attributable to fraud. HCFA is already moving to correct these systemic weaknesses.

The HHS/OIG has also been redirecting some audit efforts away from just the traditional financial and performance audits that characterized HHS/OIG's activities in the past. Instead, many audit staff are being trained at the Federal Law Enforcement Training Center, and are then available to

provide critical financial analysis and support to the Office of Investigations and DOJ on large, complex false claims cases. Audit assistance was central to the success of many of the joint initiatives this year, among them, Independent Clinical Laboratories, and the DRG 72 Hour Payment Window Project.

Medicaid

Another key HHS/OIG initiative has been to work more closely with state auditors in overseeing the Medicaid program. The HHS/OIG Office of Audit Services devised a Federal-State Partnership Plan that ensures more effective use of scarce audit resources by both the federal and state audit sectors. Partnerships have already been established with 19 state Auditors, 11 state Medicaid agencies and 2 state internal audit groups. Extensive sharing of audit ideas, approaches and objectives has taken place between federal and state auditors. Completed reports have involved a financial impact of \$140 million affecting both federal and state government funds.

Home Health

The HHS/OIG also continued its focus on fraud and abuse in the home health industry. The Office of Audit Services conducted an audit of home health claims in 4 states, and found that 40 percent failed to meet Medicare reimbursement requirements. Most often, these services were found to be unreasonable or unnecessary, were provided to beneficiaries who were not homebound, or were not supported by valid physician orders or adequate documentation. At the same time, the Office of Evaluation and Inspections completed a study that revealed that Medicare's certification process did not adequately safeguard against participation by unscrupulous or abusive providers. In response to these reports, a temporary moratorium on new certification of new home health agencies was instituted, during which time program safeguards could be improved.

Prevention

HIPAA has also allowed the HHS/OIG to redouble its efforts in preventing health care fraud and abuse. Through its new Industry Guidance Branch, the HHS/OIG, in consultation with the Attorney General, issued regulations stipulating a process for issuing written advisory opinions to the public on various legal issues arising under certain statutes enforced by HHS/OIG, including the Anti-Kickback Statute and the Civil Monetary Penalties Law. In accordance with those rules, a number of advisory opinion requests have been received and reviewed. The HHS/OIG also solicited and published proposals for modifications and additions to the so-called Safe Harbors, regulatory provisions which establish conditions for business structures or practices deemed nonabusive, and therefore, which will not be investigated or prosecuted under the Anti-Kickback Statute.

Working with DOJ, the HHS/OIG initiated a negotiated rulemaking specifically addressing anti-kickback penalties in the context of risk sharing arrangements. In another effort to avert future

fraud, the HHS/OIG and DOJ have committed to including corporate integrity provisions in major settlements. The HHS/OIG is currently staffing up to thoroughly monitor the compliance reports submitted by settling parties.

HHS/OIG continues to work with HCFA, the Administration on Aging (AoA) and various advocacy groups to develop an outreach campaign to educate beneficiaries and others who work directly with the elderly to recognize Medicare/Medicaid fraud, waste, and abuse when they encounter it, and know how and where to refer it. In this regard, the Office of Evaluation and Inspections operates an HHS/OIG Hotline, which serves as a point of contact for complaints of waste and fraud in the Medicare program (and other HHS programs). The HHS/OIG Hotline received approximately 58,000 telephone calls during the year, which resulted in more than 7,000 complaints. An estimated \$3 million in recoveries are associated with complaints resolved by HCFA and its contractors.

Another key aspect of prevention efforts is the HHS/OIG's responsibility for excluding offending providers from future participation in federal health programs. "Project WEED" is designed to improve the process whereby the Office of Investigations identifies abusive providers and, when appropriate, excludes them from Medicare and state health programs (including Medicaid). During the first year of the Program, the number of such exclusions nearly doubled, from 1,408 in 1996, to 2,719 in 1997. The majority of these exclusions were based on convictions for program-related crimes.

The HHS/OIG working with HCFA develops recommendations to correct systemic vulnerabilities detected during reviews. A number of longstanding legislative recommendations were adopted in the Balanced Budget Act of 1997 and are being implemented by HCFA. These include recommendations related to HHS/OIG work in areas such as depreciation losses on hospital sales, and program controls for home health agencies and skilled nursing facilities, extensions to Medicare Secondary Payor provisions, prescription drugs, ambulance payments and indirect medical education costs.

Health Care Financing Administration

The Health Care Financing Administration received \$5.3 million from the Account in 1997 for activities related to controlling fraud and abuse in the Medicare program. HCFAC Program funds were used for the following activities in FY 1997:

Survey and Certification Medicare Coverage Reviews - \$1.8 million

In 1997, HCFA received \$1.8 million from the HCFAC Program for Medicare coverage reviews. HCFA carries out Medicare coverage reviews by contracting with state agencies to conduct specialized surveys that are an expansion of traditional quality of care surveys. Medicare coverage review funding improved the exchange of information among HCFA, state agencies, Fiscal Intermediaries (FIs), and Regional Home Health Intermediaries (RHHIs). Medicare coverage

reviews assist the FI and/or RHHI in identifying inaccurate billing, potential coverage problems, and potential waste, fraud, and abuse. Accordingly, Medicare coverage reviews provide FIs and/or RHHIs with the information they need to assess overpayments and implement collection procedures.

The program supported the use of protocols whereby state survey and certification agencies provided information to Medicare contractors on the eligibility status of beneficiaries receiving services from laboratories, home health agencies, and skilled nursing facilities whose utilization and costs were extremely high. During 1997, 326 surveys were made in 19 states and overpayments in the amount of \$87.6 million were identified. HCFA is in the process of collecting these overpayments.

HCFA Customer Information System (HCIS) - \$1.9 million

HCIS is the automation architecture being used to support the development and distribution of Medicare specific information to the Agency's legitimate customer base. HCIS is designed specifically to counter fraud and abuse in the Medicare program and will enable HHS/OIG and DOJ personnel to target aberrant providers, reduce investigative time, and improve actual recoveries to the Medicare Trust Funds.

HCIS accomplishes this in two ways -- (1) through the availability of summarized data that can be used to focus on specific areas of interest and (2) via access to beneficiary claim level data. These functions complement one another. For example, an auditor looking for patterns of Medicare fraud can use summarized data to focus an investigation to a specific area of interest. Since the investigation is focused at this point, the number of beneficiary claim detail records needed can be kept to a minimum. The smaller request set can later be used to process a request for complete detail data in the event the preliminary investigation warrants more comprehensive analysis. The system currently houses summarized data for home health agency, skilled nursing facility, hospice, inpatient, outpatient, and physician services.

Los Alamos National Laboratory (LANL) - \$1.6 million

In 1997, HCFA extended a contract with LANL to develop methodologies to identify fraud and abuse in the Medicare program. Scientists from LANL have examined the Medicare program and have developed algorithms and techniques to identify "suspicious" providers and to identify patterns of abuse. LANL is currently applying detection algorithms to historical claims data to develop a simulation that ranks the "suspiciousness" of a claim prior to payment. LANL will continue enhancement and examination of their fraud detection algorithms, and will test these techniques with additional provider types and in different demographic areas of the Nation.

Health Resources and Services Administration

The Act mandates that the HHS/OIG and DOJ establish a national health care fraud and abuse data collection program for the reporting and disclosure of certain final adverse actions (excluding settlements in which no findings of liability have been made) taken against health care providers, suppliers, and practitioners. The Health Resources and Services Administration (HRSA) has been authorized to design, implement and operate this program, currently named the Healthcare Integrity and Protection Data Bank (HIPDB). In 1997, HRSA was allocated \$2 million for development under the Program; operating costs will be funded by user fees.

The HIPDB is being developed in stages as an all electronic system that will collect, store and disseminate reports on practitioners, providers and suppliers that have been found guilty of health related adverse actions through an adjudicated process. The reports will be made available to certain federal and state governmental authorities, including law enforcement agencies, and health plans. These same entities are mandated reporters to HIPDB.

HRSA used its National Practitioner Data Bank (NPDB) as a baseline and model in the planning and design of the HIPDB. More than 6,000 contacts and discussions with officials and representatives of other federal agencies, the major health plans and professional societies and licensing boards, and various state organizations in both the health and law enforcement communities were made for developing the initial requirements for the HIPDB. During this information gathering and requirements development phase, the concept of using the NPDB as a baseline and model was validated.

A milestone schedule has been developed for opening the HIPDB with an initial operating capability on March 10, 1998. Progress to date includes:

- implementing regulations and Notice of Proposed Rule Making (NPRM) developed and forwarded for release;
- design specifications developed and approved;
- specific design reviews conducted of key hardware and software;
- physical facility modified to accommodate the new equipment;
- equipment ordered, received and installed in the new facility;
- existing baseline NPDB software copied to the test machine; and
- software development begun.

In addition, data acquisition activities have begun that will result in data to populate the HIPDB. These activities include formal discussions with other federal agencies including:

- DOJ to acquire all federal judgments and convictions;
- HCFA to acquire Medicare and Medicaid adverse and exclusion actions; and
- Departments of Defense and Veterans Affairs to acquire disciplinary and adverse actions.

HRSA has also entered into preliminary discussions with various health care related and health professional organizations including those representing Nursing and Chiropractic Licensing Boards, to obtain information collected by them.

Office of the General Counsel

The HHS Office of the General Counsel (OGC) worked in partnership with the DOJ and other HHS components (HCFA and the HHS/OIG) to combat health care fraud and abuse. OGC was allocated \$1.8 million in HCFAC funding for 1997. These funds were instrumental in recovering misspent monies of the Medicare Trust Funds, increasing overpayment recovery litigation, and implementing legislative and regulatory changes. This has resulted in a 65 percent increase in the number of new Program Integrity Litigation items for OGC.

The increases in OGC's funding and workload were accompanied by numerous accomplishments:

- worked with U.S. Attorneys' offices in Michigan, recoveries in the Medicare Secondary Payer program rose dramatically in FY 1997, to almost \$9 million.
- assisted in recovering \$8.5 million from a provider for an overpayment relating to a closed cost year and the discovery of improper, fraudulent cost accounting methods.
- reviewed notices sent to providers suspending payments based on suspected Medicare fraud, which has led to systemic changes to the notices decreasing their vulnerability to successful legal challenges.
- pursued recovering approximately \$1.8 million in overpayments to a bankrupt Medicare-participating home health agency.

These are just a few examples of OGC's accomplishments under the HCFAC program for 1997. It is expected that the activities of the OGC will continue and expand as the program matures.

Administration on Aging

The Administration on Aging (AoA), with its vast network of state and area agencies on aging and community-based services, serves as a partner with the HHS/OIG and HCFA in the long-term federal effort to fight and prevent fraud and abuse in the Medicare and Medicaid programs.

In 1997, the AoA was allocated \$1.1 million under the Program. These funds were used to train and educate both paid and volunteer staff in the aging network, especially those associated with Older American Act programs and services, such as long-term care ombudsman, to recognize and report potential practices and patterns of fraud and abuse in the Medicare and Medicaid programs.

Additionally, AoA and its network agencies engaged in outreach and educational activities to inform and empower older persons, their families and their communities to recognize and report fraudulent and abusive situations and to prevent or minimize victimization by such behavior.

HCFAC funding resulted in the following AoA accomplishments:

- awarded 15 cooperative agreements to state units on aging to support education, training and outreach efforts to help aging network staff and volunteers to recognize and report health care fraud and abuse;
- planned and convened in collaboration with HHS/OIG and HCFA a two-day national meeting in September, 1997 for an orientation to health care anti-fraud and abuse for 116 representatives of state units on aging and other aging network agencies;
- tested targeted community outreach models in New York City, Los Angeles, suburban Chicago, IL, and Central Florida where several thousand older persons were trained to recognize and report health care fraud and empowered to minimize becoming victims of such practices;
- in collaboration with HHS/OIG and the Assistant Secretary for Planning and Evaluation initiated plans to evaluate the effectiveness of aging network staff and agencies to recognize and report Medicare fraud and abuse;
- conducted with HHS/OIG and HCFA, 10 health care anti-fraud and abuse workshops for approximately 535 aging service professionals at 8 major national and regional conferences of aging network agencies; and
- contracted with the University of Louisville to design software enhancements to report and track fraud and abuse referrals from state long-term care ombudsmen.

The training and outreach activities have already resulted in significant referrals to the HHS/OIG hotline and other investigative and enforcement agencies leading to various sanctions, recoupments and prosecutions.

FUNDING FOR DEPARTMENT OF JUSTICE

United States Attorneys

Health care fraud involves many different types of schemes that defraud Medicare, Medicaid, the Department of Veterans Affairs, or other insurers or providers. The fraudulent activity may include double billing schemes, kickbacks, billing for unnecessary or unperformed tests, or may be related to the quality of the medical care provided. Working closely with the Department of Justice Civil and Criminal Divisions, United States Attorneys' offices (USAOs) criminally and civilly prosecute health care professionals, providers, and other specialized business entities who engage in health care fraud.

USAOs have established close ties with numerous federal and state law enforcement agencies who are involved in the prevention, evaluation, detection, and investigation of health care fraud. In addition to HHS/OIG and HCFA, these agencies include the State Medicaid Fraud Control Units (MFCUs); Inspectors General Offices of other Federal agencies; the Drug Enforcement Administration; DOD, DCIS; and the TRICARE Support Office in the Department of Defense (formerly CHAMPUS).

To assist in coordination and communication at local, state and national levels, each USAO has appointed both a criminal and civil health care fraud coordinator. Additionally, a Health Care Fraud Coordinator position has been established in the Executive Office for the United States Attorneys (EOUSA) to facilitate fraud enforcement efforts. Prior to the enactment of HIPAA, USAOs dedicated substantial resources to combating health care fraud. HIPAA allocations have supplemented these efforts.

Highlights of the first year of the Program include:

Training: The EOUSA's Office of Legal Education (OLE) is tasked with the responsibility for providing health care fraud training for USAO, and DOJ attorneys, investigators, and auditors. During 1997, OLE conducted a number of presentations and complete courses on health care fraud. Notably, OLE sponsored a conference in Basic Health Care Fraud Prosecution Team Training in July 1997. Many of the attendees were newly hired USAO personnel. Due in large part to overwhelming interest in basic team training, this program was repeated for those unable to attend the first course. The second course was held in September 1997. OLE plans to sponsor six health care fraud courses for Department prosecutors and support personnel in 1998.

Additionally, USAO attorneys, investigators and auditors participated in a number of non-OLE sponsored, multi-agency health care fraud training courses over the last year.

Recruitment of Additional Prosecutors and Investigative Personnel:

On January 6, 1997, the Attorney General announced that 167 new positions for health care fraud enforcement were authorized to be filled in USAOs. These included: 60 criminal Assistant United States Attorneys (AUSAs); 30 civil AUSAs; 23 paralegals; 30 auditor/investigators; 23 support positions, and a full-time Health Care Fraud Coordinator in the Legal Programs section of EOUSA.

Accomplishments - Criminal Prosecutions

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

Each time a criminal case is referred to a USAO from the FBI, HHS/OIG, or other enforcement agency, it is opened as a matter pending in the district. A case remains a matter until an indictment or information is filed or the case is declined for prosecution. Since 1996, criminal health care fraud matters have increased by approximately 13 percent. The number of defendants the United States has been investigating and referring for prosecution has also increased; since 1996, the number of defendants involved in criminal health care fraud matters has increased by approximately 15 percent.

CRIMINAL HEALTH CARE FRAUD MATTERS		
FISCAL YEAR	MATTERS	DEFENDANTS
1997	1,517	2,479
1996	1,346	2,151
1995	1,247	2,047

The increase in matters referred to USAOs has directly resulted in an increase in criminal health care fraud prosecutions filed. During 1997, criminal health care fraud prosecutions increased by approximately 15 percent over 1996. The number of defendants the USAOs have prosecuted has also dramatically increased, a 18 percent increase over 1996.

CRIMINAL HEALTH CARE FRAUD PROSECUTIONS FILED		
FISCAL YEAR	CASES	DEFENDANTS
1997	282	531
1996	246	450
1995	229	381

Health care fraud convictions include both guilty pleas and guilty verdicts. The Department has seen a tremendous increase in the number of convictions. During 1997, criminal health care fraud convictions reached a record high, a 22 percent increase over 1996. The number of defendants convicted increased 18 percent over 1996.

CRIMINAL HEALTH CARE FRAUD CONVICTIONS		
FISCAL YEAR	CASES	DEFENDANTS
1997	217	363
1996	177	307
1995	158	255

Accomplishments - Civil Cases

Civil health care fraud efforts constitute a major focus of Affirmative Civil Enforcement (ACE) activities. The ACE Program is a powerful legal tool used to help ensure that federal funds are recovered, federal laws are obeyed, and that violators provide compensation to the government for losses and damages they cause as a result of fraud, waste, and abuse. Civil health care fraud prosecutions ordinarily involve the United States utilizing the False Claims Act to recover damages and penalties against those who defraud the government, as well as the common law of fraud, payment by mistake, unjust enrichment and conversion. Additionally, in conjunction with a defendant committing a criminal health care fraud offense, the United States may file a civil proceeding using the Fraud Injunction Statute, to ensure assets traceable to such violation are available to repay those victims the defendant has defrauded.

CIVIL HEALTH CARE FRAUD MATTERS PENDING	
FISCAL YEAR	MATTERS
1997	4,010
1996	2,488
1995	1,406

Each time a civil case is referred to a USAO it is opened as a matter pending in the district. Civil health care fraud cases and matters are referred directly from federal or state investigative agencies. In addition, our efforts to combat health care fraud are aided by private persons known as "relators," who file suits on behalf of the Federal Government under the 1986 qui tam amendments to the False Claims Act and may be entitled to share in the recoveries resulting from these lawsuits.

A matter becomes a case when the United States files a civil complaint, or intervenes in a qui tam complaint, in United States District Court. A large majority of civil health care fraud cases and matters are settled without a complaint ever being filed. 1997 civil health care fraud matters increased 61 percent over 1996.

CIVIL HEALTH CARE FRAUD CASES FILED	
FISCAL YEAR	CASES
1997	89
1996	90
1995	60

Civil Division

Civil Division attorneys and AUSAs throughout the country, working closely with the FBI, the HHS/OIG, the DOD/OIG, and other federal law enforcement agencies, as well as MFCUs, vigorously pursue civil remedies in health care fraud matters, and work on other projects that implicate the Civil Division's interests in the prosecution of health care fraud. A record setting number of new health care fraud matters were initiated by the Civil Division in 1997 -- 243 new matters is double the actions initiated in 1996, suggesting heightened enforcement emphasis for years to come.

A noteworthy success for the Department was the \$319 million independent clinical laboratory settlement with Smithkline Beecham Clinical Labs, which settled a range of allegations including

kickbacks, billing for tests not performed, and fabrication of diagnosis codes. Other matters involving clinical laboratories billing for unnecessary blood tests produced sizeable civil settlements -- \$173 million from Laboratory Corporation of America and \$81 million from Damon Labs.

Also significant are the Department's settlements with Baptist Medical Center (\$17 million), Apria Healthcare Group, Inc. (\$1.65 million), and OrNda Healthcorp (\$12.6 million) for submitting claims to Medicare for goods and services provided pursuant to prohibited kickback arrangements.

Resources play an important role in promoting the expansion of health care fraud enforcement efforts. In 1997, the Civil Division received \$9,656,000 in funds from the Account for personnel and Automated Litigation Support (ALS). Authorization for an additional 33 positions was provided, including attorneys, analysts, auditors, paralegals, a training specialist, and a litigation support specialist.

The ability to effectively coordinate among the many organizations and locations that play a role in identifying and prosecuting health care fraud is crucial to successful enforcement efforts. Accordingly, an attorney was selected in 1997 to serve as the Civil Division's health care fraud coordinator. This attorney will work on improving the Civil Division's prosecution of health care fraud, and coordinating those efforts with other DOJ components, other law enforcement agencies, and the private sector.

Major progress was made in establishing ALS services for large-scale health care fraud matters in 1997. Many health care fraud matters involve a profusion of small fraudulent actions repeated systematically on a large number of patients at multiple locations throughout the country. ALS has been used successfully to create databases to identify patterns of activity among suspected offenders and calculate potential fraud and pinpoint those responsible for the fraud.

In 1997, funding from the Account also permitted the Civil Division to hire the services of statisticians, accountants and medical consultants to support health care fraud cases and investigations. Because health care fraud perpetrators are skilled at covering their tracks under mountains of claim forms and ledger sheets, accountants knowledgeable in the financial practices of large medical entities are critical to detecting the billing schemes of unscrupulous hospitals and other providers. Also important are ALS-provided statisticians who develop sampling plans and analyses for determining the pervasiveness and monetary value of the fraud. Medical consultants review patient files to determine if the services provided were medically necessary.

Federal Bureau of Investigation

The FBI received \$3.6 million from the HCFAC for equipment, in addition to the \$47 million provided by HIPAA. (A description of the \$47 million is included in the Appendix). The equipment purchased with these funds was for enhancement of computer/technical and

surveillance inventories of multiple FBI field offices, and is dedicated for use in health care fraud investigations. The majority of the purchases were for laptop and desktop computers and enhanced computer software to assist in the complex and document intensive health care fraud matters. In addition, surveillance cameras and sophisticated consensual recording equipment was purchased. Further, several new Health Care Fraud Squads and multi-agency task forces were outfitted with standard investigative equipment.

Criminal Division

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

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

- updates on criminal, civil, administrative and regulatory efforts to combat health care fraud;
- memoranda summarizing the provisions of HIPAA distributed at the Health Care Fraud Working Group meetings and other training conferences, and updating the April 1995 Health Care Fraud manual to reflect the significant changes brought about by HIPAA distributed in the July and September 1997 training conferences on health care fraud;
- updates on significant appellate decisions concerning health care fraud prosecutions;
- development of guidance on authorized investigative demands. This provision empowers the Attorney General to issue investigative demands to obtain records for criminal investigations relating to federal criminal health care fraud offenses. These records are not subject to the constraints applicable to grand jury matters, and thus enhance the ability of USAOs to conduct parallel criminal and civil investigations.

Justice Management Division

In order for DOJ to fulfill its obligations under the Program, additional resources were placed within the Justice Management Division, Debt Collection Management Staff. The duties of this office include: budget formulation, oversight and coordinating with the Office of Management and Budget and HCFA; development and data collection for the internal program evaluation; coordinating with HHS/OIG and the Department of the Treasury on the tracking of collections; coordinating with the General Accounting Office on required audits; and preparation and coordination of the annual report.

FUNDING FOR OTHER PARTNERS IN HEALTH CARE ENFORCEMENT AND OVERSIGHT

Of the funds made available for 1997, up to \$3.5 million was set aside for enforcement activities by federal, state and local agencies (other than HHS and DOJ) that are currently involved in health care fraud and abuse detection and prevention activities. On March 26, 1997, HHS and DOJ jointly published a Notice of Availability of Funds inviting qualifying federal, state and local agencies to submit proposals to receive a portion of this money to fund projects or activities that promote the objectives of the Program. A total of 28 proposals were received and rated by a panel from HHS and DOJ. The panel recommended funding for 11 proposals (eight state governmental units, the District of Columbia, and two federal agencies) totaling \$1.55 million. The Secretary and the Attorney General adopted the recommendations of the panel, and funds were issued in July 1997. Following is a brief description of each of the funded proposals:

State of Alabama, Office of the Attorney General - \$232,700 - Funding was approved to purchase computer and transportation equipment, and provide training for investigators and auditors of the MFCU. Funds will also support a review of hospital reimbursement under Medicaid.

State of California, Office of the Attorney General, Bureau of Medi-Cal Fraud and Abuse
State of New York, Office of the Attorney General, Medicaid Fraud Control Unit - \$300,000 - Funding was provided to develop a joint automated system for managing the tasks required to investigate and prosecute cases of health care fraud. Once developed, the system will be shared with other MFCUs.

State of Colorado, Department of Health Care Policy and Financing - \$213,334 - Two projects received funding: 1) a study to detect fraud and abuse by clients and/or providers who use multiple programs; and 2) a risk-adjusted methodology for setting Medicaid Health Maintenance Organization capitation rates.

Department of Defense, Inspector General - \$195,612 - Funding was approved to purchase, on behalf of DCIS, computer hardware and software to establish 12 on-line sites for direct access, downloading and analysis of data relating to the CHAMPUS program.

District of Columbia, Department of Human Services, Department of Health, and the Medical Assistance Administration - \$83,776 - Funding was provided to purchase computer software; to provide services and training for fraud and abuse detection; and to provide electronic communication between the Government Fraud Investigative Unit and the Medical Assistance Administration.

State of Nebraska, Department of Insurance - \$100,000 - Funding was provided to acquire a computerized data base to assist in health care enforcement and oversight efforts, as well as the equipment necessary to operate it and related training in its use.

State of North Carolina, Department of Insurance - \$28,932 - Funding was granted to provide professional and technical consultation, such as physicians and statistical analysts, for investigative agencies and prosecutorial authorities, in pursuit of health care fraud enforcement.

Commonwealth of Pennsylvania, Department of Public Welfare - \$112,315 - Funding was provided to acquire new software, hardware and training to enable the agency to produce more efficient and useful provider profiles to expedite case preparation and evaluation .

State of Tennessee, Department of Commerce and Insurance - \$121,700 - Funding was granted to coordinate health care activities among law enforcement agencies, and for public and industry outreach.

State of Wisconsin, Department of Justice - \$58,988 - Funding was granted for one full-time investigator, training materials and computer equipment for a beneficiary outreach program to identify health care fraud scams over the Internet.

Department of the Treasury, Internal Revenue Service, Criminal Investigative Division - \$107,000 - Funding was provided to conduct health care fraud training seminars, including training in managed care.

APPENDIX

Federal Bureau of Investigation Mandatory Funding

"There are hereby appropriated from the general fund of the United States Treasury and hereby appropriated to the Account for transfer to the Federal Bureau of Investigation to carry out the purposes described in subparagraph (C), to be available without further appropriation-- (I) for fiscal year 1997, \$47,000,000".

Successful health care fraud enforcement cannot be achieved by any one agency alone. Investigations must be a cooperative effort if they are to be successful in combating the increasing problem of health care fraud. The FBI is involved in this cooperative effort. The FBI works many health care fraud cases on a joint basis with other federal agencies, including the HHS/OIG. These two federal agencies collaborate through attendance at health care fraud working groups, attend each others' training conferences, and have a liaison program between the two organizations. The FBI and the HHS/OIG share a common commitment to ending fragmented health care fraud enforcement.

In addition to providing new statutory tools to combat health care fraud, HIPAA specified mandatory funding to the FBI for health care fraud enforcement. The law provided the FBI with \$47 million in 1997 for its health care fraud efforts. The FBI used this funding, in large part, to fund an additional 46 agents and 31 support positions for health care fraud and to create several new dedicated Health Care Fraud squads. This increase in personnel resources increased the number of FBI agents addressing health care fraud in the fourth quarter of 1997 to the equivalent of 370 agents as compared to 112 in 1992. Funding is slated to increase incrementally until 2003, when it will reach \$114 million and remain at that level each year thereafter. With this additional funding, the FBI will continue to increase the number of agents committed to health care fraud investigations.

As the FBI has increased the number of agents assigned to health care fraud investigations, the caseload has increased dramatically from 591 cases in 1992, to 2,582 cases through 1997. The FBI caseload is divided between those health plans receiving government funds and those that are privately funded. Criminal health care fraud convictions resulting from FBI investigations have risen from 116 in 1992, to 485 in 1997*. As the complexity and long-term nature of health care

*The FBI includes in its statistics convictions obtained through State prosecutions that resulted from an FBI investigation.

fraud investigations increase, the FBI anticipates that the number of investigations and convictions will begin to level off.

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

The funding made available through HIPAA also made possible four Regional Training Conferences for FBI agents assigned to health care fraud investigations. These one-week training sessions sponsored by HCFA provided in-depth training on the Medicare Program to almost 300 agents. Other training sessions, including a session for the FBI's Financial Analysts and an FBI, DCIS, HHS/OIG Managers' Conference, were also made possible by HIPAA. Further, funding from HIPAA was utilized in Pharmacy Diversion Training and Cost Report Training to more than 100 FBI agents.

GLOSSARY

The Account - The Health Care Fraud and Abuse Control Account

ACE - Affirmative Civil Enforcement

ALS - Automated Litigation Support

AoA - Administration on Aging

AUSA - Assistant United States Attorney

CHAMPUS - Civilian Health and Medical Program of the Uniformed Services

DCIS - The Department of Defense, Defense Criminal Investigative Service

DOD - The Department of Defense

DOJ - The Department of Justice

DOL - The Department of Labor

DRG - Diagnosis Related Group

EOUSA - Executive Office for the United States Attorneys

FBI - Federal Bureau of Investigation

FI - Fiscal Intermediary

GAO - General Accounting Office

HCFA - Health Care Financing Administration

HCIS - HCFA Customer Information System

HHS - The Department of Health and Human Services

HI - Hospital Insurance Trust Fund

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

HIPDB - Healthcare Integrity and Protection Data Bank

HRSA - Health Resources and Services Administration

LANL - Los Alamos National Laboratory

MFCU - State Medicaid Fraud Control Unit

NPDB - National Practitioner Data Bank

NPRM - Notice of Proposed Rule Making

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

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

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

OPM - Office of Personnel Management

ORT - Operation Restore Trust

The Program - The Health Care Fraud and Abuse Control Program

RHHI - Regional Home Health Intermediary

USAO - United States Attorney's Office

U.S.C. - United States Code

VA - The Department of Veteran Affairs