# 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 1997[1]. 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 | |
| Gifts and Bequests | $6,750 |
| Amount Equal to Criminal Fines* | 46,162,414 |
| Civil Monetary Penalties | 732,577 |
| Amount Equal to Asset Forfeiture ** | 0 |
| Amount Equal to Penalties and Multiple Damages | 88,828,469 |
| **Health Care Financing Administration** | |
| OIG Audit Disallowances - Recovered | 302,288,607 |
| Restitution/Compensatory Damages | 560,576,678 |
| | **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 | 2,276,621 |
| | **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.

[1] In 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 | 1,100 |
| 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 | 42 |
| 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