
**The Department of Health and Human Services
And
The Department of Justice
Health Care Fraud and Abuse Control Program
Annual Report For FY 2005**

AUGUST 2006

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GENERAL NOTE

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

EXECUTIVE SUMMARY

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

Monetary Results

During FY 2005, the Federal Government won or negotiated approximately \$1.47 billion in judgments and settlements, and it attained additional administrative impositions in health care fraud cases and proceedings. The Medicare Trust Fund received transfers of nearly \$1.55 billion during this period as a result of these efforts, as well as those of preceding years, in addition to \$63.64 million in federal Medicaid money similarly transferred to the Centers for Medicare and Medicaid Services (CMS) as a result of these efforts. The HCFAC account has returned over \$8.85 billion to the Medicare Trust Fund since the inception of the program in 1997.

Enforcement Actions

In FY 2005, U.S. Attorneys' Offices opened 935 new criminal health care fraud investigations involving 1,597 potential defendants. Federal prosecutors had 1,689 health care fraud criminal investigations pending, involving 2,670 potential defendants, and filed criminal charges in 382 cases involving 652 defendants. A total of 523 defendants were convicted for health care fraud-related crimes during the year. Also in FY 2005, the Department of Justice (DOJ) opened 778 new civil health care fraud investigations, and had 1,334 civil health care fraud investigations pending at the end of the fiscal year. DOJ filed complaints or intervened in 266 civil health care cases in FY 2005.

¹Hereafter, referred to as the Secretary.

INTRODUCTION

**ANNUAL REPORT OF
THE ATTORNEY GENERAL AND THE SECRETARY
DETAILING EXPENDITURES AND REVENUES
UNDER THE HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM
FOR FISCAL YEAR 2005**

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

STATUTORY BACKGROUND

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

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

The Act appropriates monies from the Medicare Trust Fund to an expenditure account, called the Health Care Fraud and Abuse Control Account (the Account), in amounts that the Secretary and Attorney General jointly certify as necessary to finance anti-fraud activities. The maximum amounts available for certification are specified in the Act. Certain of these sums are to be used only for activities of the HHS/OIG, with respect to Medicare and Medicaid programs. In FY 2005, the Secretary and the Attorney General certified \$240.558 million for appropriation to the Account. A detailed breakdown of the allocation of these funds is set forth later in this report. These resources generally supplement the direct appropriations of HHS and DOJ that are devoted to health care fraud enforcement. These funds provide approximately 80% of HHS/OIG funding. (Separately, the Federal Bureau of Investigation (FBI) received \$114 million from HIPAA which is discussed in the Appendix.).

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

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

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

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

- (1) the amounts appropriated to the Trust Fund for the previous fiscal year under various categories and the source of such amounts; and
- (2) the amounts appropriated from the Trust Fund for such year for use by the Attorney General and the Secretary and the justification for the expenditure of such amounts.

This annual report fulfills the above statutory requirements.

MONETARY RESULTS

As required by the Act, HHS and DOJ must detail in this Annual Report the amounts deposited and appropriated to the Medicare Trust Fund, and the source of such deposits. In FY 2005, \$1.71 billion was deposited with the Department of the Treasury and the Centers for Medicare and Medicaid Services (CMS), transferred to other federal agencies administering health care programs, or paid to private persons during the fiscal year. The following chart provides a breakdown of the transfers/deposits:

Total Transfers/Deposits by Recipient FY 2005	
Department of the Treasury	
HIPAA Deposits to the Medicare Trust Fund	
Gifts and Bequests	\$30,863
Amount Equal to Criminal Fines	\$347,896,377
Civil Monetary Penalties	\$13,134,764
Asset Forfeiture *	\$0
Penalties and Multiple Damages	\$350,763,305
Subtotal	\$711,825,310
Centers for Medicare and Medicaid Services	
OIG Audit Disallowances - Recovered	\$423,334,724
Restitution/Compensatory Damages	\$413,398,752
Subtotal	\$836,733,476
Grand Total	\$1,548,558,785
Restitution/Compensatory Damages to Federal Agencies	
HHS/OIG Cost of Audits, Investigations and Compliance	
Monitoring	\$9,432,501
Office of Personnel Management	\$4,002,889
TRICARE	\$3,350,711
Administration for Children and Families	\$2,583,033
National Institutes of Health	\$1,671,755
Department of Labor	\$1,274,523
Other Agencies	\$1,313,912
Subtotal	\$23,629,324
Relators' Payments**	\$136,756,946
TOTAL ***	\$1,708,945,056

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

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

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

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

- (1) Gifts and bequests made unconditionally to the Trust Fund, for the benefit of the Account or any activity financed through the Account;
- (2) Criminal fines recovered in cases involving a Federal health care offense, including collections under section 24 (a) of Title 18, United States Code (relating to health care fraud);
- (3) Civil monetary penalties in cases involving a Federal health care offense;
- (4) Amounts resulting from the forfeiture of property by reason of a Federal health care offense, including collections under section 982(a)(6) of Title 18, United States Code; and
- (5) Penalties and damages obtained and otherwise creditable to miscellaneous receipts of the general fund of the Treasury obtained under sections 3729 through 3733 of Title 31, United States Code (known as the False Claims Act, or FCA), in cases involving claims related to the provision of health care items and services (other than funds awarded to a relator, for restitution or otherwise authorized by law).

PROGRAM ACCOMPLISHMENTS

EXPENDITURES

In the ninth year of operation, the Secretary and the Attorney General certified \$240.558 million as necessary for the Program. The following chart gives the allocation by recipient:

FY 2005 ALLOCATION OF HCFAC APPROPRIATION (Dollars in thousands)	
Organization	Allocation
Department of Health and Human Services	
Office of Inspector General ³	\$160,000
Office of the General Counsel	4,778
Administration on Aging	3,128
Centers for Medicare and Medicaid Services	22,297
Health Resources and Services Administration	450
Office of the National Coordinator for Health Information Technology (ONC)	490
Subtotal	\$191,143
Department of Justice	
United States Attorneys	\$30,400
Civil Division	14,459
Criminal Division	1,580
Civil Rights Division	1,976
Nursing Home Initiative	1,000
Subtotal	\$49,415
Total	\$240,558

³In addition, HHS/OIG obligated \$1.71 million in funds received as "reimbursement for the costs of conducting investigations and audits and for monitoring compliance plans" as authorized by section 1128C(b) of the Social Security Act, 42 U.S.C. § 1320a-7c(b).

ACCOMPLISHMENTS

Overall Recoveries

During this fiscal year, the Federal Government won or negotiated approximately \$1.47 billion in judgments and settlements, and it attained additional administrative impositions in health care fraud cases and proceedings. The Medicare Trust Fund received transfers of nearly \$1.55 billion during this period as a result of these efforts, as well as those of preceding years, in addition to \$63.64 million in federal Medicaid money similarly transferred to CMS as a result of these efforts. Note that some of the judgments, settlements, and administrative actions that occurred in FY 2005 will result in transfers in future years, just as some of the transfers in FY 2005 are attributable to actions from prior years.

In addition to these enforcement actions, numerous audits, evaluations and other coordinated efforts yielded recoveries of overpaid funds, and prompted changes in Federal health care programs that reduce vulnerability to fraud. In FY 2005 HHS collected more than \$423 million in HHS/OIG recommended recoveries.

Program Accomplishments

Working together, HHS/OIG, DOJ and their law enforcement partners have brought to successful conclusion the investigation and prosecution of numerous health care fraud schemes. During FY 2005, the many significant HCFAC Program accomplishments included the following:

Pharmaceutical Fraud

- GlaxoSmithKline paid the United States \$140 million to settle allegations of fraudulent drug pricing and marketing that resulted in the submission of inflated claims to Medicare, Medicaid, and other federally funded health care programs. The United States alleged that GlaxoSmithKline, one of the world's largest pharmaceutical manufacturers, reported inflated prices for the drugs, Zofran and Kytril, knowing that those prices would be used by federal programs to set reimbursement rates. GlaxoSmithKline used the artificial spread between the reported, inflated prices and its customers' significantly lower actual cost to purchase the drugs as a marketing tool. Zofran and Kytril are anti-emetic drugs used primarily to reduce the negative side effects of radiation and other cancer treatments. The settlement was the result of a *qui tam* suit filed by Ven-A-Care of Florida Keys, Inc., a small home-infusion company, and its principals. In addition to the \$140 million federal share of the recovery, GlaxoSmithKline paid \$10 million to reimburse state Medicaid funds.

- AdvancePCS, in the pharmacy benefit management business, paid the United States \$138.5 million to resolve allegations that AdvancePCS exacted kickbacks, disguised as administrative fees and sales and service agreements, from drug manufacturers in

exchange for marketing their drugs to providers reimbursed by federally insured health programs; accepted kickbacks in the form of cash payments and rebates from drug manufacturers in exchange for marketing their drugs to providers reimbursed by federally insured health programs; and paid kickbacks to providers reimbursed by federally insured health programs to ensure that AdvancePCS was selected or retained as the pharmacy benefit manager for the health plans.

Pharmaceutical Distribution Fraud

- A pharmacist and former principal owner and president of King Drugs, Inc. in Kentucky pleaded guilty to illegally selling prescription drug samples to the public through King Drugs pharmacies after repackaging the samples. The pharmacist obtained the samples by taking them from various doctors and purchasing the samples from others and then led the public to believe that the drugs were properly obtained and dispensed as required by law. In resolving both criminal and civil actions with the United States, the defendant paid (jointly with the company) more than \$10.5 million to the government, relinquished his pharmacy license, agreed to permanent exclusion from all federal health benefit programs, and will serve a sentence involving home confinement and 48 months of probation.
- An individual based in Las Vegas, Nevada who sold prescription drugs and controlled substances over the internet was convicted by a jury of 17 felony counts and sentenced to 120 months in prison. The defendant shipped the drugs to his customers in the United States through a German business he owned called CFF Pharma Consult. One of the drugs the defendant sold online was Flunitrazepam, commonly known as Rohypnol, or the “date rape drug.” The drugs the defendant sold were shipped from Germany to the United States through the use of forged and fraudulent documents designed to deceive employees of the United States Customs Service and the Food and Drug Administration (FDA). In addition to the ten-year prison sentence, the court ordered forfeiture of the defendant’s home valued at \$285,000 because it was used to facilitate the drug offenses. A co-defendant also pleaded guilty to conspiracy to defraud and was sentenced to 37 months in prison.
- Convictions resulted for nine individuals in the Miami, Florida area who engaged in a multi-million dollar Medicare fraud scheme regarding local medical clinics that were fraudulently billing for expensive medications used to treat conditions common among persons with Human Immunodeficiency Virus (HIV) and persons undergoing cancer treatment. Several doctors and their co-conspirators used the Bolanos Institute and Lefebvre Institute to fraudulently bill Medicare for intravenous infusion treatments involving medications, Neupogen and Procrit, that were either not provided to patients or were not medically necessary. The doctors falsified patient medical diagnoses and documentation in order to help conceal the fact that the patients were not receiving the Neupogen and Procrit treatments that were billed to Medicare.

- An owner of numerous internet pharmacy websites was sentenced in the Eastern District of Virginia to 33 months in prison for illegally distributing controlled substance weight loss drugs and other prescription drugs over the internet to consumers. The court ordered forfeiture of approximately \$6 million worth of vehicles, homes, jewelry, bank accounts, and other property that the government had seized, and also entered a \$16 million order of forfeiture. Two of the defendant's companies, Chhabra Group, LLC, and VKC Consulting, LLC, were also convicted of conspiracy to commit money laundering. Eleven individuals, including five physicians and two pharmacists, pleaded guilty or have been found guilty in this scheme.

- A California man was sentenced to serve 51 months in prison and to forfeit cash proceeds for operating one of the largest internet pharmacy schemes ever prosecuted. Customers visiting his on-line pharmacy filled out a questionnaire and paid a \$35 fee for a physician's consultation, after which the ostensible physician would issue a prescription and the customer would receive the pharmaceuticals. In fact, there was no physician associated with the internet pharmacy at all. Not only were drugs dispensed without any physician's review, but drugs labeled as the "generic" forms of Viagra, Cialis, Levitra, Propecia, Celebrex and others were actually counterfeit drugs illegally imported into the United States without FDA's quality controls and public health safeguards. The individual pled guilty to conspiring to sell counterfeit drugs, mail fraud, and illegal importation or smuggling of drugs into the United States.

- As reported in the HCFAC Report for FY 2004, after a jury trial, a Texas pharmacist was convicted for his role in distributing hydrocodone and other controlled substances via his web-based pharmacy. The pharmacist has been sentenced to 20 years in prison. Customers had only to complete a short on-line questionnaire to receive the controlled substances. The pharmacist and his co-conspirators found doctors, paid per prescription, who were willing to sign thousands of prescriptions without ever seeing the patients. The scheme netted over \$8 million in sales. This marked the first time that the kingpin statute was used to prosecute an internet pharmacy.

Hospital Fraud

- HealthSouth Corporation paid the United States \$327 million to settle allegations of fraud against Medicare and other federally insured health care programs. The United States alleged that HealthSouth, the nation's largest provider of rehabilitative medicine services, engaged in three major schemes to defraud the government. The first, comprising \$170 million of the settlement amount, resolved HealthSouth's alleged false claims for outpatient physical therapy services that were not properly supported by certified plans of care, administered by licensed physical therapists, or for one-on-one therapy as represented. Another \$65 million resolved claims that HealthSouth engaged in accounting fraud which resulted in overbilling Medicare on hospital cost reports and home office cost

statements. The remaining \$92 million resolved allegations of billing Medicare for a range of unallowable costs, such as lavish entertainment and travel expenses incurred for HealthSouth's annual administrators' meeting at Disney World and other claims. Government-initiated claims accounted for \$251 million of the settlement amount, with the remaining \$76 million attributable to four *qui tam* law suits. HealthSouth also entered into a corporate integrity agreement (CIA) with the HHS/OIG to prevent future misconduct.

- Cleveland Clinic Florida Hospital paid \$2.75 million to the United States to resolve allegations that the hospital billed Medicare for observation services for patients at the Florida hospital that did not qualify for reimbursement under the Medicare program. The settlement agreement resolved allegations by the United States that from 1993 to 2001 the hospital failed to comply with Medicare coverage requirements, as prescribed and defined by CMS, regarding beneficiaries that have been placed in "observation status" in order to receive treatment or be monitored before making a decision concerning their next placement. In particular, the settlement agreement resolved allegations that Cleveland Clinic frequently billed Medicare for extra observation charges during normal recovery periods following minor surgery or emergency room visits. Under Medicare rules, the cost for monitoring a patient's status is, in most cases, built into the cost of the whole procedure. To claim an additional "observation" charge, the hospital must meet specific criteria, such as unexpected complications.
- The Eisenhower Medical Center in Rancho Mirage, California paid the United States \$8 million to settle allegations that it fraudulently overbilled federal health insurance programs. The settlement resolves allegations made against Eisenhower in a *qui tam* lawsuit filed by a former employee. The lawsuit alleged that Healthcare Financial Advisors helped its hospital clients seek reimbursement for unallowable costs and specifically alleged that it helped clients prepare two cost reports – an inflated one submitted to Medicare – and a second one designed for internal use only that accurately reflected the amount of reimbursement the hospital should have received.

Dialysis Fraud

- Gambro Healthcare paid the United States \$310 million to resolve allegations concerning the submission of false claims to Medicare and Medicaid in connection with dialysis services. The allegations against Gambro included: providing home dialysis patients with equipment and supplies through a sham durable medical equipment (DME) company to increase Medicare reimbursement; billing for phantom supplies; billing for ancillary medications and services that were not medically necessary – a requirement for Medicare reimbursement; and paying kickbacks to physicians for referring patients to Gambro clinics in violation of the Medicare Anti-Kickback Statute.

Gambro also paid \$15 million to resolve state Medicaid liabilities. In addition, Gambro Supply Corporation, the sham DME company and a wholly-owned subsidiary of Gambro Healthcare, paid a \$25 million criminal fine and agreed to permanent exclusion from the Medicare program.

- The Hospital of St. Raphael in Connecticut entered into a civil settlement agreement and agreed to pay the United States \$632,000 to resolve allegations that it improperly charged Medicare for treatment for kidney dialysis patients. Dialysis patients need surgically created fistula or grafts for vascular access during dialysis treatment. The fistula/grafts often become dysfunctional and need to be repaired or replaced. These procedures are usually performed under local anesthesia in an outpatient setting. If performed in an outpatient setting, Medicare pays the provider approximately \$1,500. However, if the patient is admitted to the hospital, even for one night, Medicare pays the provider approximately \$13,000. Allegedly, St. Raphael unnecessarily admitted Medicare beneficiaries to the hospital for the procedures in question and many of the beneficiaries could have been treated on an outpatient basis, at far less cost to the Medicare program. The United States also alleged that St. Raphael admitted patients for one night stays for these types of procedures far more often than other hospitals in Connecticut. St. Raphael entered into a CIA with the HHS/OIG designed to ensure compliance with the requirements of the Medicare program.

Fraud on Community Health Centers

- After an eleven-day trial, a jury found five individuals and a company, Duncan Drugs, guilty of health care fraud involving the Community Mental Health Center of East Central Georgia (CMHC). CMHC was a public agency that received millions of dollars in federal assistance annually. While a member of the Georgia House of Representatives, one of the defendants used his influence to insert a co-defendant as the business manager, and then executive director of CMHC. Through his placement as executive director, this individual fraudulently diverted more than \$2 million of CMHC's funds and directed kickbacks of over \$900,000 to the defendant in the Georgia House, which he used, in part, to fund a failed re-election campaign for the House and a failed mayoral campaign. The former Georgia House member was sentenced to 120 months in prison and ordered to pay \$1.46 million in restitution and a forfeiture money judgment of \$400,000. The former executive director of CMHC was sentenced to 72 months in prison and ordered to pay \$1.47 million in restitution. Other defendants in this scheme included a local pharmacist, a former professional baseball player, and the grandson of a former Georgia Speaker of the House; these defendants were ordered to serve 52 months, 37 months, and 33 months in prison, respectively, with full restitution ordered to the federal government.

- The former director of Kickapoo Community Health Services in Eagle Pass, Texas was sentenced to 15 years imprisonment and ordered to pay over \$100,000 in restitution. Kickapoo Community Health Services was established by the Kickapoo Traditional Tribe of Texas and is federally funded by the United States Indian Health Service. A jury found the defendant guilty of one count of theft from a health care benefit program and two counts of money laundering for stealing funds that were to be used to pay healthcare providers for medical treatment and medications for Kickapoo tribal members.

Medicaid Fraud

- A district court in Indiana sentenced a dentist to 57 months imprisonment for a Medicaid fraud scheme relating to the provision of dental services for juveniles from the defendant's mobile office. The defendant induced the parents or guardians of Medicaid-eligible patients to bring the children to him by offering, for example, gift cards or free compact disk players. The defendant would then submit claims to the Indiana Medicaid program for treatments that were not provided or were not medically necessary. In this manner, the defendant fraudulently obtained in excess of \$2.4 million in Medicaid funds. Two corporations also pleaded guilty and were each sentenced to three years probation. The defendants were ordered to pay over \$2.4 million in restitution and in excess of \$70,000 to the Indiana Attorney General's Office for the costs of investigation incurred by the state's Medicaid Fraud Control Unit.
- A former Florida Medicaid employee filed a *qui tam* suit against the University of Miami alleging that it double-billed and overcharged Medicaid through several of its outpatient clinics. The employee contended that both the University and its outpatient clinics billed Florida Medicaid under their respective provider numbers for the same covered services provided to the same beneficiaries on the same date. The United States and the State of Florida also alleged that the University submitted claims for a facility fee in connection with primary care services provided to Medicaid recipients in circumstances where the University knew that these fees were not a covered item under the provisions of the Florida Medicaid program. The United States and Florida settled this matter with the University for almost \$3.9 million.
- A licensed pharmacist who was also president and owner of Pierce Pharmaceuticals, Inc. was sentenced to 33 months imprisonment and ordered to pay over \$2 million in restitution to the North Carolina Medicaid program. Pierce Pharmaceuticals provided prescription drugs to patients who were residents in long term care facilities in North Carolina. The defendant had his company submit claims for payment to the Medicaid program for refilling prescriptions that, in fact, had not been refilled, delivered, or even requested by the various long term care facilities with which it had contracts. As a result, the Medicaid program paid over 39,000 false claims to Pierce Pharmaceuticals.

Chiropractic Fraud

- The owners and operators of twelve chiropractic/medical clinics in Ohio pleaded guilty to conspiring to commit health care fraud by billing Medicare and private health care benefit programs \$4.8 million for noncovered chiropractic services for which they were ultimately paid \$1.7 million. The defendants owned a chain of chiropractic clinics and converted them to joint chiropractic and medical clinics so they could use medical doctor billing numbers to avoid limitations on chiropractic care and bill for noncovered services. The company, MedBack, fraudulently billed for all chiropractic services using Current Procedural Terminology (CPT) codes for physical therapy or for office visits to the medical doctor. When the insurance plans correctly denied payment for noncovered chiropractic services, the owners sent appeal letters falsely stating that a medical doctor had performed all services and that the MedBack clinics did not provide chiropractic services. The defendants agreed to pay \$1.7 million in restitution and be excluded from federal health care benefit programs for fifteen years.

Podiatry Fraud

- A podiatrist in Ohio was sentenced to 135 months in prison and ordered to pay restitution of over \$1.7 million, as well as forfeit three Ohio properties following his second conviction on health care fraud charges. Previously, in 1998, the defendant pleaded guilty to upcoding claims submitted to Medicare for nursing home podiatry services. He was ordered not to bill Medicare for eight years, and, as a term of his supervised release, to tell his Probation Officer if he became involved, directly or indirectly, in any entity that billed Medicare. The State of Ohio also permanently revoked his license to practice podiatric medicine. Even as he was pleading guilty in 1998, however, the defendant was already scheming to keep control of his practice and its Medicare revenues. The defendant made it appear that he sold his practice to another podiatrist and pretended to transfer financial control of the practice to another individual, all while continuing to control and expand the practice, and using its Medicare revenues to pay his own expenses. On a loan application for a home paid for with Medicare funds, the defendant listed his own assets but listed the other individual as the borrower and used that person's credit history to obtain the loan. In addition to health care fraud and conspiracy to commit health care fraud, the defendant was convicted of mail fraud, false statements, and bank fraud.

Ambulance Services Fraud

- Adventist Health System Sunbelt Healthcare Corporation, and a management company that administered ambulance operations at three hospitals affiliated with the company agreed to pay the government \$20.3 million to settle allegations that they billed Medicare for ambulance transports that were not medically necessary. To support these claims, the management company and the hospitals allegedly created false physician certifications regarding the medical necessity of ambulance trips.

Kickbacks

- PharMerica, Inc., and PharMerica Drug Systems, Inc., entered a settlement agreement with the HHS/OIG to resolve allegations that the companies paid unlawful kickbacks in connection with a purchase of a small Virginia pharmacy. In what was the largest settlement of a civil monetary penalties (CMP) kickback case to date, PharMerica agreed to pay more than \$5.9 million to the government. A leading supplier of pharmacy services to long term care institutions, PharMerica allegedly overpaid for the pharmacy in return for a commitment from the seller – who also owned 17 nursing homes -- to refer its Medicare and Medicaid pharmacy business to PharMerica for the following seven years. The HHS/OIG alleged that PharMerica’s acquisition amounted to the unlawful purchase of referrals of federal health care program business from the nursing facility chain. PharMerica also entered into a five-year CIA with the HHS/OIG.

False Claims by a Research University

- The University of Alabama at Birmingham and two related entities will pay the United States \$3.39 million to settle allegations that they violated the False Claims Act (FCA) with respect to claims submitted in connection with the school’s health science research activities. The settlement resolves allegations that, in completing applications for federal health science research grants, the school overstated the percentage of work effort that the researchers were able to devote to the grant. It was also alleged that the university, and the entity through which its medical school faculty provide clinical services, unlawfully billed Medicare for clinical research trials that were also billed to the sponsor of research grants.

Fraudulent Health Insurance Provider

- A San Francisco executive was sentenced to 41 months in prison and ordered to pay \$1.3 million in restitution for operating a fraudulent health insurance scheme that defrauded thousands of people across the United States. The victims purchased health insurance plans from the company, only to discover after illnesses or accidents that their health insurance was essentially worthless. According to the charges, the phony health insurance company collected over \$2.8 million in premiums but deposited only a small fraction of those funds into trust accounts. Instead, the defendant spent much of the money on his personal expenses, paying salaries to members of his family, leasing expensive cars, buying football tickets, and paying commissions to so-called promoters who helped market the fraudulent plan.

Durable Medical Equipment Fraud

- Polymedica Corporation and its subsidiaries Liberty Medical Supply, Inc., and Liberty Home Pharmacy Corporation agreed to pay the United States \$35 million to resolve allegations that they submitted improper claims to Medicare for various diabetic and nebulizer products. Claims were allegedly submitted without required doctor's order or prescription, and the companies failed to obtain and maintain documentation verifying the necessity of the level of treatment rendered. The companies also allegedly billed Medicare without written authority from a patient to do so. Under the terms of this settlement, Polymedica Corporation and/or its subsidiaries also agreed to comply with a CIA negotiated by the HHS/OIG.
- The owner of a California medical supply company pled guilty to health care fraud for billing Medicare for power wheelchairs, hospital beds and other equipment that was never prescribed by a physician, and never received by the beneficiaries. The individual was charged with having defrauded Medicare of some \$2.4 million over five years. As part of the plea agreement, the owner agreed to forfeit his home, vehicles and bank accounts to pay restitution to the government.
- The owner of a medical equipment company in Oklahoma was sentenced to serve 5 months in prison and to pay more than \$340,000 in restitution after pleading guilty to health care fraud. She admitted to forging doctors' names on phony certificates of medical necessity. She furnished patients with scooters valued at \$1,500, but billed the Medicaid program for electronic wheelchairs at \$5,000.
- Apria Healthcare Group Inc., the nation's largest supplier of DME, paid the United States \$17.6 million to settle two civil FCA cases filed against Apria by former employees. The settlements resolved allegations that between mid-1995 through 1998, Apria submitted false documents certifying medical necessity; failed to obtain written prescriptions from physicians prior to delivery of equipment when required to do so; failed to notify patients of their option to purchase DME; and misrepresented the date or place equipment was delivered to patients.

Obstruction of a Federal Audit

- Charges of unlawful kickbacks against OPI Properties, Inc., a subsidiary of the Swiss Novartis Corporation were resolved with OPI pleading guilty to nine felony counts of attempting to obstruct a federal audit. OPI was ordered to pay \$4.5 million to the government and was permanently excluded from Medicare and Medicaid. Under a separate civil agreement, Novartis Nutrition Company, also a subsidiary of the Swiss company, agreed to pay over \$44 million to the United States.

Both actions arose from an undercover operation in which various manufacturers and distributors of enteral nutrition products offered kickbacks to federal agents operating a storefront distributor of medical supplies. OPI provided free equipment to the phony distributor in exchange for a long-term contract involving services to Medicare patients, then created false invoices for the free items, instructing the undercover agents to produce the dummied invoices in the event of a Medicare audit. The civil settlement resolved allegations that OPI and Novartis Nutrition caused false claims to Medicare in connection with arrangements that violated the Medicare Anti-Kickback Statute. Novartis Nutrition entered a five year CIA with HHS/OIG.

Physician Fraud

- A Virginia physician specializing in pain management was sentenced to 25 years imprisonment and ordered to pay a \$1 million fine for his conviction on drug distribution charges and drug trafficking that resulted in one death and serious injuries to others. During the six-week trial, the Government demonstrated that he performed perfunctory exams on patients, and then facilitated the patients' demand for excessive amounts of controlled substances, including OxyContin. Evidence showed that the physician knew that patients were abusing the controlled substances, or selling them to others.

Medicare Contractor Fraud

- United Healthcare Insurance Company agreed to pay the United States \$3.5 million to settle allegations that the company defrauded the Medicare program. As a former DME Regional Carrier, United Healthcare contracted with CMS to process Medicare claims for DME submitted by providers, suppliers and Medicare beneficiaries in the Northeastern United States. The government alleged that United Healthcare's telephone response unit knowingly mishandled phone inquiries received from Medicare beneficiaries and providers and then falsely reported its performance information to CMS concerning the company's handling of those calls.

Teaching Hospital Physicians' Fraud

- The University of Medicine and Dentistry of New Jersey agreed to pay the federal government \$1.4 million to resolve allegations that the medical schools falsely represented that services billed to Medicare were personally provided by teaching faculty, when there was insufficient documentation that those physicians were "personally and identifiably involved" in the care. This marks the last of the government's several cases brought as part of an initiative to review rules governing Medicare payments to physicians at teaching hospitals.

Quality of Care Issues

Another area in which collaboration among the federal authorities responsible for health oversight has proved most effective has been in enforcement and oversight of issues relating to quality of care, as demonstrated by the following:

- A joint federal-state investigation of a nursing home owned by Hillcrest Healthcare, Inc., disclosed egregious quality of care problems at the Connecticut facility. One resident had died of septic infection allegedly caused by improperly treated bedsores; others suffered from severe pressure sores and pressure ulcers, dehydration, and weight loss. The government also alleged that the home failed to employ adequate staffing, and failed to follow plans of care. By consent order, the home surrendered its license and paid the state \$200,000. The company pled nolo contendere in state court to charges of Manslaughter in the Second Degree arising out of the death of the resident. The company entered a civil settlement with the federal government to resolve allegations of submitting false claims to Medicare and Medicaid. Hillcrest agreed to pay a total amount of \$750,000. In addition, Hillcrest agreed to be permanently excluded from the Medicare and Medicaid programs. Hillcrest sold the facility to new owners in December 2004.
- The United States entered a civil settlement agreement with Central Montgomery Medical Center over the Pennsylvania hospital's alleged quality of care deficiencies. The agreement marked the first settlement for failure of care based upon alleged violations of regulatory requirements relating to use of physical and chemical restraints. The government alleged that the hospital knowingly billed for numerous patients who were improperly physically and/or chemically restrained in violation of federal law, in one case ending in the death of a restrained elderly patient. The hospital agreed to pay the government \$200,000 and to hire a consultant to review restraint usage at the facility.
- After a five week trial, a jury found a now-defunct suburban Pittsburgh nursing home and its former administrator guilty of health care fraud and numerous false statements relating to health care matters. The evidence presented at trial established that the nursing home administrator and Atrium I Nursing and Rehabilitation Center engaged in a scheme to defraud Medicare and Medicaid of more than \$7 million from 1999 through August 2003. The scheme involved a failure to provide required care for Atrium residents, most of whom were diagnosed with Alzheimer's disease. The defendants falsely represented they were providing appropriate care, and concealed deficiencies from regulatory agencies by the extensive falsification of records.
- Boston Scientific Corporation of Massachusetts paid \$74 million to address the company's illegal distribution of the Nir ON Ranger with Sox premounted coronary stent delivery system. Boston Scientific recalled the device from the market less than two months after commercial launch because of a manufacturing defect that affected its safety and effectiveness. The settlement ended an investigation that was initiated in 1998 by DOJ. The United States alleged that Boston Scientific shipped more than 30,000 adulterated and misbranded devices to hospitals throughout the country. The government accused Boston

Scientific of continuing to ship the devices for weeks after an internal investigation had determined that a substantial number of the devices were not functioning properly. On October 5, 1998, Boston Scientific management notified the FDA that the company was immediately stopping shipments of the device and was pulling the product from the market. Nevertheless, later that day, Boston Scientific shipped an additional 833 units to hospitals throughout the country. According to the FDA, the defect was responsible for 26 injuries, including several surgeries to remove a dislodged stent. The settlement was paid as an equitable monetary penalty.

FUNDING FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General

Certain of the funds appropriated under HIPAA are, by law, set aside for Medicare and Medicaid activities of HHS/OIG. In FY 2005, The Secretary and the Attorney General jointly allotted \$160 million to the HHS/OIG which is the statutory maximum permitted under HIPAA. This is equal to the amount allotted to the HHS/OIG in 2003 and 2004. This represents approximately 80 percent of the HHS/OIG's overall funding.

The HHS/OIG participated in investigations or other inquiries that resulted in 799 prosecutions or settlements in FY 2005, of which 633 or 79% percent were health care cases. A number of these are highlighted in the Accomplishments section. During FY 2005, the HHS/OIG also excluded a total of 3,804 individuals and entities, barring them from participating in Medicare, Medicaid, and other federal and state health care programs. In addition, the Department of Health and Human Services collected more than \$423 million in disallowances of improperly paid health care funds, based on HHS/OIG recommendations.

Program Savings

Frequently, investigations, audits and evaluations reveal vulnerabilities or incentives for questionable or fraudulent financial practices in agency programs or administrative processes. As required by the Inspector General Act, the HHS/OIG makes recommendations to agency managers to address these vulnerabilities. In turn, agency managers recommend legislative proposals or other corrective actions that, when enacted or implemented, close loopholes and reduce improper payments or conduct. The net savings from these joint efforts toward program improvements can be substantial. During FY 2005, HHS/OIG estimates that such corrective actions resulted in health care savings (i.e., funds put to better use as a result of implemented legislative or other program initiatives) of approximately \$30 billion -- nearly \$22.9 billion in Medicare savings, and more than \$7.5 billion in savings to the Medicaid program. Additional information about savings achieved through such policy and procedural changes may be found in Appendix A to the HHS/OIG Semiannual Report, on-line at <http://oig.hhs.gov/reading/semiannual.html>

Exclusions

One important mechanism for safeguarding the care provided to program beneficiaries is through exclusion of providers and suppliers who have engaged in patient abuse or neglect or fraud. During FY 2005, the HHS/OIG excluded a total of 3,804 individuals and entities. Among these were exclusions based on criminal convictions for crimes related to Medicare or Medicaid (770), or to other health care programs (264); for patient abuse or neglect (325); or as a result of licensure revocations (2,012). Among those excluded by the HHS/OIG were the following:

- ▶ A certified nurse aide (CNA) in Colorado was excluded for 25 years as a result of being convicted for sexual assault against an elderly nursing home patient who suffered from Alzheimer's. The aide was sentenced to serve 15 years-to-life in prison.
- ▶ An Oklahoma pediatrician was excluded for 50 years based on his conviction for abuse of minor patients. The physician confessed to abusing 18 children, all under the age of 16, over a period that spanned 20 years.
- ▶ A DME sales representative in Florida was excluded for 28 years after his conviction for participating in a scheme to bill Medicare for millions of dollars in medically unnecessary DME items.
- ▶ A South Carolina physician was excluded for 26 years after his conviction for his part in a scheme to sell prescriptions for controlled substances such as OxyContin and Percocet.

Other Administrative Enforcement Actions – Civil Monetary Penalties

The Office of Inspector General has authority to impose civil monetary penalties (CMPs) against providers and suppliers who knowingly submit false claims to the government, who participate in unlawful patient referral or kickback schemes, who fail to appropriately treat or refer patients who present at hospital emergency rooms, or who engage in other activities proscribed in statute. The HHS/OIG has stepped up its affirmative enforcement actions under these authorities. The PharMerica case discussed previously is one example. Others are:

- ▶ The Visiting Nurse Association of Washington, D.C. (now MedStar Health Visiting Nurse Association) and its home office, Visiting Nurse Association, Inc., agreed to pay more than \$1.3 million to resolve its liability for allegedly filing Medicare cost reports containing services that were not provided as claimed. The inquiry involved alleged transactions with related third parties that were not disclosed or documented. The company also entered a five-year CIA.
- ▶ A former hospital Chief Executive Officer (CEO) in Nebraska entered an agreement with the HHS/OIG to resolve his potential liability for allegedly paying kickbacks to a physician in the form of loan guarantees, consultant fees and discounts in exchange for referral of Medicare business. The CEO, too, received annual bonuses that allegedly were based on the referrals. The hospital previously entered a settlement agreement with the United States to resolve potential liability under the FCA for the same alleged conduct.
- ▶ St. Joseph Mercy-Oakland Hospital in Michigan agreed to pay \$4 million for allegedly violating the anti-kickback statute and Stark law in connection with financial arrangements between the hospital and more than a dozen physician groups. The hospital voluntarily disclosed the potential violations under the HHS/OIG's "Provider Self-Disclosure Protocol."

Studies, Audits, and Evaluations

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

Medicaid. The HHS/OIG has continued its stepped-up oversight of a number of state questionable practices and financing schemes designed to maximize federal payments under Medicaid.

- ▶ **School-Based Health Services.** Medicaid covers certain school-based health services for children with disabilities or special needs. Audits disclosed that some states had insufficient controls to ensure that school health services claims were legitimate. As an example, an audit of New York's program identified almost \$436 million in improper federal payments for school-based speech services, and more than \$96 million for transportation services. Eighty-six of 100 sampled claims for speech services in New York City did not comply with federal and state requirements for documenting services, referrals from appropriate medical professionals, and provider qualifications. As for transportation, HHS/OIG concluded that none of the 120 claims sampled complied with applicable requirements. Deficiencies included lack of documentation, failure to render other Medicaid-covered services on the day transportation services were billed, and failure to document the need for transportation services.

HHS/OIG also reviewed three other states' school-based health programs to determine whether claims for school-based services were eligible for federal reimbursement. In audits of the Maine, Massachusetts, and Vermont health programs, HHS/OIG identified over \$15.5 million in overpayments. HHS/OIG has recommended that CMS recover the federal payments made for services in all of these states, and, as appropriate, take steps to make certain state controls are sufficient to prevent impropriety in the future.

- ▶ **Intergovernmental Transfers.** States sometimes make payments to public providers, and then require the providers to return a large portion of those payments, yet still collect the federal share of these illusory payments. The HHS/OIG reviewed public nursing homes in New York, Tennessee, and Washington to determine whether Medicaid payments to the nursing homes were adequate to cover their operating costs and whether there was a link between the quality of care provided to the facilities' residents and the amount of Medicaid funding received. The HHS/OIG found that while initial Medicaid payments to the facilities were adequate to cover costs, the net Medicaid funding the facilities were allowed to retain did not meet their operating costs because the state and/or county required the facilities to return 90 to 96 percent of the upper payment limit payments they received. Over a 3-year period, the funding deficits were \$25 million, \$22.8 million, and \$290,000 for the New York, Tennessee, and Washington facilities, respectively.

- ▶ Upper-Payment Limit Calculations. HHS/OIG audited four states' upper payment limit (UPL) payments to determine whether states calculated the UPLs for hospitals and non-state government facilities in accordance with federal requirements and approved state plans. As a result of the audits, the HHS/OIG recommended that the states – Kansas, Oregon, New Jersey, and North Carolina – refund a total of approximately \$212 million in unallowable Medicaid payments.
- ▶ Disproportionate Share Hospital (DSH) Payments. States are required to make DSH payments to compensate hospitals for the uncompensated costs of serving an inordinate number of low-income patients with special needs. Audits in Illinois found that DSH payments to one hospital exceeded the hospital-specific limit imposed under the Social Security Act by \$140.3 million, and overpayments to another hospital totaled \$4.5 million. The HHS/OIG recommended that the state refund these overpayments.

Medicare Group Purchasing Organizations

- ▶ Group purchasing organizations (GPOs) leverage the purchasing power of their members (primarily hospitals and other health care providers) to secure discounts on medical supplies for those members. Vendors also pay administrative fees to GPOs, in exchange for administrative services and for the opportunity to sell through a GPO to its members. The HHS/OIG reviewed three large GPOs that collectively received \$1.8 billion in administrative fees during the audit period. Of this amount, \$1.3 billion was net revenue in excess of operating costs. The GPOs distributed \$898 million of this excess revenue to its members.

Medicare rules generally require providers to offset purchase discounts, allowances, and refunds against expenses on their Medicare cost reports. The HHS/OIG reviewed 21 GPO members, and found that they did not fully account for net revenue distributions on their Medicare cost reports. There was considerable variation among the GPOs, with members of one GPO offsetting 92 percent of the distributions, members of another offsetting only 54 percent. In total, 22 percent of net revenue distributions were not offset. The HHS/OIG recommended that CMS issue specific guidance regarding the treatment of GPO net revenue distributions on Medicare cost reports. Separately, the HHS/OIG determined that the 21 GPO members generally offset vendor rebates on their Medicare cost reports, as required.

Drug Pricing

- ▶ Medicaid Federal Upper Limit (FUL) Drug List. Under Medicaid, CMS is required to establish federal maximum reimbursement levels for certain multiple source drugs. CMS has set and published these FULs for over 400 drugs. However, a review found that CMS does not consistently add qualified drugs to the upper limit list in a timely manner. Of the 252 first-time generic drugs approved between January 2001 and December 2003, 109 met the criteria for inclusion on the FUL list, but only 25 were actually added to the list. For those drugs that were added, CMS took an average of 36 weeks to place the products on the FUL list. Had the drugs been added to the list in a timely manner, the HHS/OIG estimated that Medicaid would have saved \$167 million.
- ▶ HHS/OIG conducted a series of studies that continue to examine whether Medicaid is overpaying for prescription drugs. Two companion studies examined the published prices states use to set Medicaid reimbursement rates and concluded that the Medicaid drug reimbursement rates are higher than statutorily-defined prices based on actual sales. The HHS/OIG recommended that Medicaid base its reimbursement on pricing data that more closely reflect pharmacy acquisition costs. The HHS/OIG also examined FUL rates established by CMS for certain generic drugs and found FUL to be, on average five times higher than average manufacturer prices for the same drugs in 2004. If Medicaid based its upper limit rates on reported average manufacturer prices, the program could save hundreds of millions of dollars.

Oversight of CMS Error Rate Testing

- ▶ CMS operates two programs to develop a fee-for-service (FFS) Medicare error rate; the Hospital Payment Monitoring Project (HPMP) generates an error rate for inpatient acute care hospital claims, and the Comprehensive Error Rate Testing program (CERT) produces a rate for other provider claims. Together, these produce an overall annual Medicare FFS paid claims error rate that is reported to the Congress.

The HHS/OIG audited aspects of both of these programs. For hospital services, the audit concluded that HPMP contractors generally followed appropriate criteria for determining medical necessity of claimed services, and for designating correct diagnosis-related groups (DRG). There were minor inaccuracies in calculations for claims for certain corrected-, DRGs, but the inaccuracies were not statistically significant.

For other provider claims, HHS/OIG reviewed controls in place to ensure the integrity of the CERT contractor's processes for reviewing 120,000 claims each year. The CERT contractor requests and reviews medical records underlying these sampled claims. If providers fail to produce the records, the contractor follows up with calls and letters. The contractor also selects certain claims for "quality assurance reviews."

The HHS/OIG found that though the contractor had appropriate controls to assure the soundness of medical reviews, the contractor had fallen behind in its quality assurance reviews. CMS agreed to award a second CERT contract to reduce the workload, and allow the contractor to keep current on its required quality monitoring.

- ▶ In a related study, HHS/OIG concluded that provider responsiveness to CMS contractor requests for medical records for use in determining the CERT error rate had improved. Provider non-responses did not have a statistically significant impact on the calculation of the overall error rate.

Medicare Outlier Payments

- ▶ Medicare pays additional payments, beyond DRG payments, to compensate hospitals for treating unusually costly patients. To stem excessive growth in claims for these “outlier payments,” in 2003 CMS issued regulations revising rules for calculating such payments. The HHS/OIG examined outlier payments at more than 350 hospitals and determined that the regulations have reduced outlier payments by nearly 43 percent. CMS estimated that the new outlier rules would save in excess of \$9 billion over five years.

Family Planning Service Costs

- ▶ The federal government reimburses the costs of family planning services at an enhanced 90-percent matching rate. These services are intended to prevent or delay pregnancy or to otherwise control family size. In several reviews, HHS/OIG found that states did not always comply with appropriate requirements, including the provisions of their respective state plans, for charging these costs to Medicaid. One state retroactively claimed an increase of more than \$11 million as the difference between regular federal matching rates and the enhanced 90-percent rate for prior family planning expenditures. Of this amount, more than \$6 million was determined to be unallowable. In another state, claims for family planning service costs were overstated by \$3.7 million (\$1.4 million in federal reimbursement) because the state improperly claimed these costs at the enhanced family planning rate.

Industry Outreach and Guidance

- ▶ Advisory Opinions. Central to the HIPAA guidance initiatives is an advisory opinion process through which parties may obtain binding legal guidance as to whether their existing or proposed health care business transactions run afoul of the federal anti-kickback statute, the CMP laws, or the exclusion provisions. During FY 2005, the HHS/OIG, in consultation with DOJ, issued 18 advisory opinions. A total of 132 advisory opinions were issued during the first nine years of the HCFAC program.
- ▶ Supplemental Compliance Guidance for Hospitals. The HHS/OIG periodically works with specific industry sectors to develop guidance, tailored to that sector, on how to prevent the submission of false claims or other impropriety. In FY 2005, HHS/OIG issued

supplemental guidance to hospitals, that builds on guidance issued seven years earlier. The “Supplemental Compliance Guidance for Hospitals” includes an expanded risk section that points out areas of significant risk for hospitals. It also offers suggestions on how hospitals might identify potential problems, and how they might assess the effectiveness of their compliance programs. The Guidance may be found at <http://oig.hhs.gov> under “Fraud Prevention and Detection.”

- ▶ **Corporate Integrity Agreements.** Many health care providers that enter agreements with the government to settle potential liabilities for violations of the FCA also agree to adhere to a separate CIA. Under these agreements, the provider commits to establishing a program or taking other specified steps to ensure its future compliance with Medicare and Medicaid rules. At the close of FY 2005, the HHS/OIG was monitoring more than 370 CIAs.

Centers for Medicare & Medicaid Services

In FY 2005, the Centers for Medicare and Medicaid Services (CMS) was allocated \$22.3 million to fund a variety of projects related to fraud, waste and abuse in the Medicare and Medicaid programs. Of this amount, approximately \$19 million was specifically dedicated to combat fraud in the State Children’s Health Insurance (SCHIP) and Medicaid programs.

CMS has increased its efforts to use advanced technology to detect and prevent fraud and abuse and to ensure that CMS pays the right providers, the right amount, for the right service, on behalf of the right beneficiary. Projects include:

Payment Error Rate Measurement (PERM):

PERM is the program that CMS uses to implement the Improper Payments Information Act of 2002 that requires HHS to measure improper payments in Medicaid and the SCHIP. During FY 2005, CMS revised its approach to measure Medicaid and SCHIP improper payments using a national contracting strategy rather than requiring states to do the measurement. CMS will initially develop a Medicaid FFS error rate in FY 2006. CMS used FY 2005 HCFA funds to begin funding contracts for statistical and documentation support needed to begin measuring the Medicaid FFS error rates in FY 2006. When the improper payments measurement is completed for FY 2006, CMS will report the error rates and will use the results to help states plan corrective actions to reduce the rate of improper payments in their programs.

Medicaid/SCHIP Financial Management Project:

During FY 2004, CMS hired and began training 100 accountants and financial analysts to improve the financial management and fiscal oversight of the Medicaid program. Since then, staff have reviewed states’ operating plans prior to the beginning of the fiscal year so that problems or issues could be resolved before claims are submitted. They performed in-depth reviews of funding sources such as donations, taxes, certified public expenditures, intergovernmental transfers, and state and local appropriations to verify that they are allowable non-Federal funding sources.

The CMS goal is to eliminate the current need to disallow Federal Medicaid funding after it has already been spent by states, and instead to identify any unallowable funding schemes or expenditures before they occur.

Medicaid Audits

In FY 2005, HCFAC funds were allocated to CMS to support a series of special Medicaid audits conducted by the HHS/OIG through an Interagency Agreement with CMS. Approximately 20 audits were undertaken in states and issue areas specified by CMS. The major targeted areas included: school based services, administrative costs, skilled professional medical personnel and provider overpayments.

Medicare/Medicaid Data Match Expansion Project (Medi-Medi)

In FY 2005, HCFAC funds were used by CMS to continue operations in nine Medi-Medi project states which included Texas, Illinois, North Carolina, Florida, New Jersey, Pennsylvania, Ohio, Washington, and California. These developed from the original matching project in California which started operations in February 2002. The Medi-Medi project examines the health care claims data from two programs that share many common beneficiaries and providers to look for billing patterns that may be indicative of potential fraud or abuse that may not be evident when provider billings from either program are viewed in isolation.

Since inception, the Medi-Medi projects have yielded 335 investigations with an estimated \$182 million at risk.⁴ In addition, as a result of the Medi-Medi projects, 42 cases were referred to law enforcement, and over \$4.7 million in overpayments were identified for recovery. In FY 2005, CMS added a tenth Medi-Medi state, New York. Finally, individual Medi-Medi projects continue to uncover a variety of health care fraud schemes. One of the most notable items uncovered at the end of FY 2005 came in the form of a vulnerability reported by the Pennsylvania Medi-Medi project. The Program Safeguard Contractor, working in conjunction with the state, uncovered a weakness in the process for billing and processing pharmaceutical drug claims stemming from the Medicare program and the Medicaid program using different procedure coding systems. As a result, \$20 million in potential overpayments were identified for calendar year 2004 alone. Significantly, CMS has preliminary indications that this same vulnerability may exist across all of the Medi-Medi projects, and will further explore this vulnerability.

⁴ Dollar amount at risk: The dollar amount paid to the provider for the potential fraudulent behavior under investigation for the time period for which fraud is suspected up to a maximum of three years. For example, these estimates may be dollars paid for a specific code or service under review, the dollars paid in duplicate in a double-billing scheme, or dollars paid for services beyond 16 hours in a day. In future reporting periods, this amount may change based on further investigation, medical review, or the calculation of an overpayment. Experience has shown that the dollar amount at risk associated with a potential data-analysis lead will become more precise and reliable as the investigation matures.

Office of the General Counsel

The Office of the General Counsel (OGC) provides legal support consistent with the statutory authority of the HCFAC program. OGC was allocated \$4.778 million in HCFAC funding in FY 2005 to support program integrity activities. OGC reviews programs and activities of CMS in order to strengthen them against potential fraud, waste, and abuse, to prevent the wrongful disbursement of program funds in the first instance, consistent with the statutory goals of HCFAC. OGC accomplishments in FY 2005 include the following:

False Claims Act (FCA) and Qui Tam Actions

- ▶ OGC provided litigation support and advice to the Commercial Litigation Branch of DOJ, and the United States Attorneys in actions relating to Medicare or Medicaid fraud under the FCA. For example, OGC participated in the global settlement with HealthSouth, the nation's largest provider of rehabilitation services.

Criminal Prosecutions

- ▶ During work on a CMP administrative case, OGC discovered and developed evidence in a case involving a former executive with Iowa's largest nursing home chain. OGC referred the matter to the USA, and the former executive was subsequently indicted for obstruction of a federal audit, conspiracy, and making false statements to federal officials. Two nurses were also indicted in the same matter, and the corporate owner entered into a settlement paying \$500,000 in penalties.

Civil Monetary Penalties (CMPs)

- ▶ OGC represented CMS in 900 plus new administrative matters in FY 2005, with nearly half of these being formal appeals before the Departmental Appeals Board. CMP recoveries against nursing homes, due to favorable administrative decisions, negotiated settlements, and favorable court decisions totaled over \$8.9 million.

Suspensions

- ▶ OGC's advice to CMS regarding two medical suppliers that submitted DME claims based on forged prescriptions influenced CMS's decision to suspend payment to the supplier who is now facing criminal charges of defrauding Medicare of \$2.4 million.

- ▶ OGC worked on multiple cases centered around the suspension of a common billing company for DME suppliers in South Florida that resulted in improper Medicare payments of almost \$100 million in a period of only three to four months.

Enforcement of Medicare and Medicaid Participation Standards

- ▶ OGC assisted in defending a nursing home's appeal to the Sixth Circuit Court of Appeals in which the final administrative decision included findings of substantial non-compliance at the immediate jeopardy level and the imposition of a CMP of \$4,050 per day.

Affirmative Overpayment Litigation

- ▶ OGC assisted in collecting over \$60 million in overpayments from Medshares, one of the nation's largest home health care chains, and continues to represent Medicare's interest in the bankruptcy of Intrepid USA, a nationwide home health company that assumed significant repayment obligations to CMS with the acquisition of the remaining assets of Medshares. OGC obtained Intrepid's repayment in full of the Medshares-related obligations.

Review of Regulations Implementing the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA)

The goal of program integrity review – in which OGC reviews CMS's programs and activities in order to strengthen them against potential fraud, waste, and abuse – is to prevent the wrongful disbursement of program funds in the first instance. During FY 2005, OGC reviewed several rules implementing various provisions of the MMA. For example:

OGC worked closely with CMS on the development of the final rule implementing the new Medicare Part D prescription drug benefit, scrutinizing the rule from a program integrity perspective to minimize opportunities for fraud, waste, and abuse in the new multi-billion dollar program. OGC also helped CMS draft the compliance plan requirements for Part D sponsors and worked closely with law enforcement to coordinate how CMS rules and policies can assist in the investigation and prosecution of entities committing fraud and abuse.

Policy Guidance, Education, and Coordination of Fraud and Abuse Control Activities

CMS relies upon provider and beneficiary education programs to lower the number of erroneous Medicare claims. OGC expanded its efforts, in conjunction with CMS and its state partners, to provide regular training sessions with surveyors from the state agencies under contract with CMS.

OGC attorneys throughout the country address bar associations and other private legal groups as part of the department's outreach efforts regarding the requirements of the Medicare Secondary Payer statute. Such outreach events help to reduce Medicare expenditures and sensitize the legal community to recognizing that individuals must reimburse Medicare when the cost of treatment is paid by someone else. Examples include a panel discussion of Medicare nursing home issues at the annual conference of the American Association of Public Welfare Attorneys; and a presentation to the Missouri Bar Association Committee on Elder Law regarding nursing home enforcement procedures and the new prescription drug program.

Administration on Aging

In FY 2005, the Administration on Aging (AoA) was allocated \$3.128 million in HCFAC funds to develop and disseminate consumer education information to older Americans, with a particular focus on persons with low health literacy, individuals from culturally diverse backgrounds, persons living in rural areas, and other vulnerable populations. AoA and its nationwide network of agencies supported community education activities designed to assist older Americans and their families to recognize and report potential errors or fraudulent situations in the Medicare and Medicaid programs.

Senior Medicare Patrol (SMP) Projects recruit retired professionals to educate and assist Medicare beneficiaries to detect and report health care fraud, error, and abuse in Medicare and Medicaid programs. According to the last performance information from the Assistant Inspector General for Evaluation and Inspections, over the 12-month period, ending June 30, 2005, the 57 SMP projects trained over 6,400 new senior volunteers; these volunteers perform an essential function of this program in sharing the SMP message within the senior community.

Outreach to senior consumers is a key element of the SMP program. During FY 2005, projects conducted over 28,000 media events and held close to 7,300 community education events to increase beneficiary awareness about issues related to Medicare and Medicaid integrity. As a result of these efforts, over 372,000 beneficiaries were educated, either in group or one-on-one sessions.

As a result of educating beneficiaries, the projects received over 18,300 complaints. While the SMP program staff were able to address the majority of these issues for beneficiaries, almost 1,000 were referred to Medicare contractors or other responsible agencies for follow-up. Almost 700 of these complaints resulted in money recouped to the Medicare program or another action taken by the Medicare contractor or investigative agency. In total, SMP projects documented over \$110,000 recouped to the Medicare program during this period. The projects also reported over \$17,000 in savings to the Medicaid program, and savings of approximately \$194,000 to beneficiaries. On July 1, 2005, one-year capacity-building grants were awarded to Guam and the U.S. Virgin Islands to extend program coverage to seniors not previously reached in these U.S. territories.

While it is not possible to directly track all of the cases reported and dollars recovered through SMP community education activities, or quantify the "sentinel effect" in fraud costs avoided due to increased consumer awareness, approximately \$104.3 million has been reported as savings attributable to the program since its inception.

Office of the National Coordinator for Health Information Technology

In FY 2005, the Office of the National Coordinator for Health Information Technology (ONC) was allocated \$490,000 to conduct a six-month project to determine how the use of health information technology can enhance and expand health care anti-fraud activities. The project involved two main tasks: 1) a descriptive study of the issues and steps in the development and use of automated coding software that enhance healthcare anti-fraud activities; and 2) identifying best practices to enhance the capabilities of a nationwide interoperable health information technology infrastructure to assist in prevention, detection and prosecution in cases of healthcare fraud or improper claims and billing.

A report for automated coding software identified the characteristics of automated coding software tools that have the potential to detect improper coding; prevent improper or potentially fraudulent coding practices. The report also identified the characteristics that relate to the role of electronic health records; and, developed a set of recommendations for software developers and users of coding products to maximize anti-fraud practices and prevention measures.

A second report identified best practices to enhance the capabilities of a nationwide interoperable health information technology infrastructure to assist in health care fraud prevention, detection and prosecution. The report described how potentially fraudulent activities can be prevented from occurring through the use of new technologies. In addition, the report included an economic impact model to serve as a framework for tracking fraud and non-fraud related costs/benefits associated with developing and implementing a nationwide interoperable health information network with interoperable electronic health records.

Health Resources and Services Administration

In FY 2005, \$450,320 in HCFAC funds were allocated to the Health Resources and Services Administration for supplemental funding of the Healthcare Integrity and Protection Data Bank (HIPDB) to supplement the overall operations and maintenance of the program. The primary focus of the HIPDB is to prevent or reduce fraud and abuse in the medical system and to enhance quality health care by serving as a repository for collecting, maintaining, and reporting on final adverse actions taken against health care providers, suppliers and practitioners.

This information helps prevent practitioners, providers, and suppliers with problem backgrounds from moving from state to state unnoticed by licensing, government and health plan officials, thus improving health care quality. It also assists law enforcement officials in their efforts against health care fraud and abuse.

The HIPDB opened for reporting in 1999, and as of September 30, 2005, the HIPDB contained 223,775 reports of health care related civil judgments, criminal convictions, injunctions, licensing and certification actions, exclusions from state and federal health care programs, and other adjudicated actions involving 129,526 individuals and 4,879 organizations.

As of September 30, 2005, the HIPDB had responded to 5,291,625 queries from state and Federal agencies (including law enforcement) and health plans. The HIPDB has processed over 6.5 million queries since 2000 and maintains over 223,000 reports.

FUNDING FOR DEPARTMENT OF JUSTICE

United States Attorneys

In FY 2005, the United States Attorney's Offices (USAOs) were allocated \$30.4 million in HCFAC program funds to support civil and criminal health care fraud and abuse litigation as exemplified in the Program Accomplishment's section. The USAOs dedicated substantial resources to combating health care fraud and abuse in FY 2005. HCFAC allocations have supplemented those resources by providing dedicated positions for attorneys, paralegals, auditors and investigators, as well as funds for litigation of resource-intensive health care fraud cases.

The 93 United States Attorneys and their assistants, or AUSAs, are the nation's principal prosecutors of federal crimes, including crimes committed by health care providers. Civil attorneys in the USAOs are responsible for bringing affirmative civil cases to recover funds that federal health care programs have paid as a result of fraud, waste, and abuse, with support in those cases designated by the Civil Division for joint handling. USAOs also handle most criminal and civil appeals at the federal appellate level.

In addition to the staff positions funded by HCFAC, the Executive Office for the United States Attorneys' (EOUSA) Office of Legal Education (OLE) uses HCFAC funds to train AUSAs and other Department attorneys, as well as paralegals, investigators, and auditors in the investigation and prosecution of health care fraud. In FY 2005, OLE conducted courses and presentations on health care fraud, including the Health Care Fraud Coordinator's Conference for Civil and Criminal AUSAs and Health Care Fraud for new AUSAs.

Criminal Prosecutions⁵

In FY 2005, the USAOs received 935 new criminal matters involving 1,597 defendants, and had 1,689 health care fraud criminal matters pending,⁶ involving 2,670 defendants. The USAOs filed criminal charges in 382 cases involving 652 defendants, and obtained 523 federal health care related convictions. USAOs receive referrals of criminal health care fraud cases from a wide variety of sources, including the FBI, the HHS/OIG, state Medicaid Fraud Control Units, and other federal, state, and local law enforcement agencies.

⁵FY 2005 criminal data does not include data for the month of September 2005 for the Eastern District of Louisiana due to Hurricane Katrina.

⁶When a USAO accepts a criminal referral for consideration, the office opens it as a matter pending in the district. A referral remains a matter until an indictment or information is filed or it is declined for prosecution.

Civil Matters⁷

The USAOs use affirmative civil enforcement litigation to recover monies wrongfully taken from the Medicare Trust Fund and other taxpayer-funded health care systems, and to ensure that the federal health care programs are fully compensated for the losses and damages resulting from such thefts. The False Claims Act (FCA) is one of the most important tools the USAOs use for these purposes. The FCA subjects those who knowingly present false claims for payment to the government, including health care providers who submit claims to federal health care programs, to treble damages and civil penalties.

USAOs receive civil health care fraud referrals from a variety of sources, including from the federal investigative agencies that refer criminal cases, and by means of *qui tam* complaints. Under the FCA, a *qui tam* plaintiff (known as a “relator”) must file his or her complaint under seal in a United States District Court, and serve a copy of the complaint upon the USAO for that judicial district, as well as the Attorney General. USAOs routinely assign civil AUSAs to every *qui tam* case filed in their districts, as well as all matters referred by a law enforcement agency. In FY 2005, the USAOs opened 778 new civil health care fraud matters (including *qui tam* actions and matters referred by agencies) and had 1,334 civil health care fraud matters and cases pending. In order to maximize resources, Civil Division attorneys may become actively involved and participate with the USAOs in those *qui tam* cases that involve more than one district and potential recoveries substantially over one million dollars. In addition to these joint cases, USAOs are responsible in all other *qui tam* cases for investigating the relator’s allegations and, where appropriate, litigating and/or settling the case. In FY 2005, USAOs filed or intervened in 266 civil health care fraud cases.

Civil Division

In FY 2005, the Civil Division was allotted \$15.459 million in HCFAC funds to support civil health care fraud litigation (this amount includes \$1 million allotted for the Nursing Home and Elder Justice Initiative). Civil Division attorneys pursue civil remedies in health care fraud matters, working closely with the USAOs, the FBI, the HHS/OIG and the Department of Defense, CMS, and other federal and state law enforcement agencies. Cases involve providers of health care services, supplies and equipment, as well as carriers and fiscal intermediaries, that defraud Medicare, Medicaid, TRICARE, the Federal Employee Health Benefit Program (FEHBP), and other government health care programs.

In FY 2005, the Division opened or filed a total of 306 health care fraud cases or matters. In addition to these new efforts, the Civil Division pursued 642 existing cases or matters that remained open at the end of FY 2004. Civil Division attorneys were actively involved in the recoveries described in the consolidated case recovery overview.

⁷FY 2005 civil data does not include data for the month of September 2005 for the Eastern District of Louisiana due to Hurricane Katrina.

In addition, the Civil Division provided in-depth, multi-day, training to AUSAs nationwide on the FCA, including issues relating to the investigation and litigation of *qui tam* cases, and continued to provide training to DOJ and HHS components on a regular basis.

Civil Division attorneys litigate a wide range of health care fraud matters, including cases involving allegations of overcharging by hospitals, and other Medicare Part A institutional providers; similar claims against suppliers of DME and other supplies under Part B of Medicare; similar allegations involving state Medicaid programs; claims that doctors and others have been paid kickbacks or other remuneration to induce referrals of Medicare or Medicaid patients, in violation of the Anti-Kickback Act and Stark laws; claims of overpricing and illegal marketing of pharmaceuticals by drug companies and related entities; and allegations that nursing homes have failed to provide necessary care to elderly and vulnerable residents. Among these are multi-district cases involving large health providers and suppliers that typically require coordination among affected federal agencies, USAOs, state Medicaid Fraud Control Units and other state agencies, and various investigative organizations.

The Civil Division continues to staff and provide a critical coordination function in the FCA investigations alleging pharmaceutical pricing fraud against government health care programs. These matters involve hundreds of manufacturers and related entities, span multiple districts and present myriad legal and factual issues. Civil Division attorneys have spearheaded substantial efforts to share information and evidence, as appropriate, with the USAOs and other components of DOJ, as well as HHS components, including the FDA. In addition, close communication with state Medicaid Fraud Control Units and Attorneys General is ongoing to ensure that federal and state investigations and litigation are coordinated. Since 1999, eighteen cases involving allegations of fraud by pharmaceutical manufacturers against federal health benefit programs in the pricing or marketing of drugs have been settled by the Department for total criminal and civil recoveries of \$4.2 billion.

Civil Division attorneys, working with attorneys in the Criminal Division and EOUSA, have played a critical role in coordinating and presenting the views of the Department of Justice to the Centers for Medicare and Medicaid Services as that agency drafts implementing regulations for the new Medicare prescription drug benefit passed as part of MMA. Civil Division attorneys also played a critical role in coordinating and presenting DOJ's views to the HHS/OIG as it interpreted and applied the Anti-Kickback Statute and Stark laws (prohibiting physician self-referral). In addition, the Division worked with other components of DOJ to provide views on the Hospital Compliance Program Guide published by the HHS/OIG.

In addition to these accomplishments, the Department's Nursing Home and Elder Justice Initiative, coordinated by the Civil Division, among other things, supports enhanced prosecution and coordination at federal, state and local levels to fight abuse, neglect, and financial exploitation of the nation's elder and infirm population.

Through this Initiative, the Department also makes grants, in coordination with the Office of Justice Programs, to promote research, develop training curricula and materials, improve scarce forensic knowledge, and enhance prevention, detection, intervention, investigation, and prosecution of elder abuse.

The Department additionally continues to pursue cases relating to providers' egregious failures to provide required care, usually resulting in harm, suffering, and sometimes death of those for whom the care was intended.

Civil Division attorneys continue to provide guidance and training to government attorneys in numerous subject matters, including to assure the Department's continued compliance with the Health and Human Services Standards for Privacy of Individually Identifiable Health Information, commonly known as the HIPAA privacy rule. Also, the Civil Division continues to co-chair with the Criminal Division the National Level Health Care Fraud Working Group to coordinate the health care fraud enforcement activities of all concerned federal and state agencies.

Criminal Division

The Criminal Division was allocated \$1.58 million in HCFAC funds to support criminal health care fraud litigation, prevention and interagency coordination in FY 2005. The Fraud Section of the Criminal Division develops and implements white collar crime policy and provides support for the federal white collar enforcement community, which includes the Division's health care fraud and abuse responsibilities. Since the inception of the HCFAC program, a major focus of the Fraud Section has been to investigate and prosecute fraud in federal health care programs and the nation's health care delivery system. The Fraud Section is responsible for handling and coordinating complex health care fraud litigation nationwide. The Fraud Section also supports the USAOs with legal and investigative guidance and, in certain instances, provides trial attorneys to prosecute criminal fraud cases.

In FY 2005, the Fraud Section provided guidance to FBI agents, AUSAs and Criminal Division attorneys on criminal, civil and administrative tools to combat health care fraud, and worked on an interagency level through:

- coordinating large scale multi-district health care fraud investigations;
- providing frequent advice and written materials on confidentiality and disclosure issues arising in the course of investigations and legal proceedings regarding medical records; including HIPAA medical privacy requirements, compliance with the Substance Abuse Patient Medical Records Privacy Act and regulations, and coordinating referrals from the Department of Health and Human Services Office of Civil Rights of possible criminal violations of the HIPAA privacy statute;

- monitoring and coordinating Departmental responses to major regulatory initiatives, legislative proposals, and enforcement policy matters related to prevention, deterrence and punishment of health care fraud and abuse;
- reviewing and commenting on numerous requests for advisory opinions submitted by health care providers to the HHS/OIG, and consulting with the HHS/OIG on draft advisory opinions per the requirements of HIPAA;
- working with USAOs and CMS to improve Medicare contractors' fraud detection and case development work;
- preparing and distributing to all USAOs and FBI field offices periodic updates on major issues, interagency initiatives, and significant activities of DOJ's health care fraud component organizations as well as periodic summaries of recent cases; and
- organizing and overseeing, in conjunction with the Civil Division, the National Level Health Care Fraud Working Group to address fraud in health care and managed care, as well as other interagency working groups formed to address specific cases and initiatives.
- During FY 2005, Fraud Section staff, along with representatives from the Civil Division and the USAOs, participated extensively in final interagency planning and rule-making efforts necessitated by the revision or expansion of several key government health care programs, including planning for the roll-out of the Medicare Part D prescription drug benefit program. The Fraud Section reviewed and commented on draft regulations for: the Medicare Part D program; the MMA-mandated revisions to the Medicare Advantage program; the new Retiree Drug Subsidy program; and a new electronic prescribing initiative and program (which included proposed "safe harbor" provisions for electronic prescribing).

The Fraud Section also collaborated with HHS/OIG and CMS officials to develop guidance, manuals, and procedures to prevent, detect, and report fraud and abuse in the Medicare prescription drug program; and to train prosecutors, investigative agents and support personnel on the provisions of the Medicare prescription drug program and on possible fraud schemes which might materialize once the program is operational.

The Fraud Section, along with the EOUSA health care fraud coordinator, staffed an interagency project sponsored by the ONC whose final report specified guiding principles and recommendations for integrating anti-fraud and evidentiary control measures into emerging electronic health record and health information technology.⁸

⁸See ONC-sponsored report on anti-fraud activities and health information technology at: <http://www.hhs.gov/healthit/hithca.html>.

In FY 2005, the Fraud Section handled or was involved in investigations of hospitals, vocational rehabilitation and healthcare management services, and other health care-related entities. Along with the USAO for the Southern District of Mississippi, Fraud Section attorneys prosecuted fourteen individuals who participated in a scheme to create bogus prescription histories and file fraudulent claims against a \$400 million settlement fund established by the manufacturer of the diet drugs Redux and Pondimin, commonly known as “Fen-Phen,” for medical injuries caused by the inappropriate prescription of these products. As of September 30, 2005, a total of 17 defendants were convicted in this multi-year ongoing joint investigation.

Civil Rights Division

In FY 2005, the Civil Rights Division was allocated \$1.98 million in HCFAC funds to support Civil Rights Division litigation activities related to health care fraud. The Civil Rights Division pursues relief affecting public, residential health care facilities. The Division has also established an initiative to carry out the Department’s goals to eliminate abuse and grossly substandard care in Medicare and Medicaid funded nursing homes and other long-term care facilities.

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

Fiscal Year 2005 Accomplishments

As part of the Department’s Institutional Health Care Abuse and Neglect Initiative, and as an enhancement to the Department’s ongoing CRIPA enforcement efforts, the Special Litigation Section staff reviewed conditions and services at 44 health care facilities in 22 states during the fiscal year. The task in preliminary inquiries is to determine whether there is sufficient information supporting allegations of unlawful conditions to warrant formal investigation under CRIPA. The Section reviews information pertaining to areas such as abuse and neglect, medical and mental health care, use of restraints, fire and environmental safety, and placement in the most integrated setting appropriate to individual needs.

The Section found that conditions and practices at two state-operated facilities for persons with mental illness and one state-operated facility for persons with developmental disabilities violate the residents' federal constitutional and statutory rights. Those facilities are: Napa State Hospital in Napa, California, the Vermont State Hospital in Waterbury, Vermont, and the Woodbridge Developmental Center in Woodbridge, New Jersey.

The Section entered settlement agreements to resolve its investigations of two publicly-operated nursing homes and two state-operated facilities for persons with developmental disabilities. Those facilities were: Nashville Metropolitan Bordeaux Hospital in Nashville, Tennessee, the Mercer County Geriatric Center in Trenton, New Jersey, the Glenwood Developmental Center in Glenwood, Iowa and the Woodward Developmental Center in Woodward, Iowa.

The Section continued its investigations of the following residential facilities for persons with developmental disabilities: Agnews, Sonoma, and Lanterman Developmental Centers in California; Holly Center in Maryland; Fort Wayne Developmental Center in Indiana; Rainier Residential Rehabilitation Center and Frances Haddon Morgan Centers in Washington; Conway Developmental Center in Arkansas; Lubbock State School in Texas; and Bellefontaine Developmental Center in Missouri.

In addition, the Section continued its investigations of the following residential facilities for persons with mental illness: Metropolitan State Hospital in California; Broughton, Cherry, Dorothea Dix, and John Umstead Hospitals in North Carolina; and St. Elisabeth's Hospital in the District of Columbia.

Finally, the Section continued its investigations of the following publicly-operated nursing homes: A. Holly Patterson Nursing Home on Long Island, New York; the Charlotte Hall Veterans Home in Maryland; and the Laguna Honda Hospital and Rehabilitation Center in San Francisco, California. In many of these investigations, negotiations toward settlement are continuing regarding the correction of the remaining deficient conditions. In some of these matters, the Section is reviewing voluntary compliance to improve conditions.

In addition to its law enforcement activities regarding health care fraud activities, the Special Litigation Section is responsible for representing the Department and the Civil Rights Division on an inter-agency committee on elder care issues. The Section has also participated in public education and outreach by speaking and participating at conferences on quality of care in health care facilities.

APPENDIX

Federal Bureau of Investigation Mandatory Funding

“There are hereby appropriated from the general fund of the United States Treasury and hereby appropriated to the Account for transfer to the Federal Bureau of Investigation to carry out the purpose described in subparagraph (C), to be available without further appropriation - (I) for fiscal year 2005, \$114,000,000.”

In FY 2005, the FBI was allocated \$114 million in HCFAC funds for health care fraud enforcement. This yearly appropriation was used to support 806 positions (466 Agent, 340 Support) in FY 2005, a decrease of 19 positions from the positions supported in FY 2004 (13 Agent, 6 Support). The FY 2005 funding did not allow for cost of living increases, necessitating reductions in funded staffing levels. The number of pending investigations has shown steady increase from 591 cases in 1992 to 2,547 cases through FY 2005. FBI-led investigations resulted in 500 criminal health care fraud convictions and 589 indictments and informations being filed in state and federal courts in FY 2005.

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

Health care fraud investigations are considered a priority within the White Collar Crime Program Plan. In addition to being a partner in the majority of investigations listed in the body of this report, the FBI launched the "Outpatient Surgery Center Initiative" to combat the growing problem of fraudulent surgeries performed at certain outpatient surgery centers located in the Southern California area. This nationwide scheme has drawn participants from 48 of the 50 states who have traveled to California to have unnecessary surgery in exchange for a cash kickback or plastic surgery, and has resulted in billings to the insurance companies in excess of \$750 million, as reported in the Annual Health Care Fraud and Abuse Control Program Report for FY 2004. The FBI partnered with the NHCAA to collect intelligence on the problem, and launched a nationwide initiative. To date, there are pending outpatient surgery center investigations in eleven field offices with more than 60 subjects identified.

The majority of funding received by the FBI is used to pay personnel costs associated with the 806 funded positions. Funds not used directly for personnel matters are used to provide operational support for major health care fraud investigations and national investigations currently focusing on pharmaceutical fraud and outpatient surgery centers. Further, the FBI continues to support individual investigative needs such as the purchase of specialized equipment and expert witness testimony on an as-needed basis.

Glossary Of Terms

The Account - The Health Care Fraud and Abuse Control Account

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

AUSA - Assistant United States Attorney

CEO - Chief Executive Officer

CERT - Comprehensive Error Rate Testing Program

CIA - Corporate Integrity Agreement

CMP - Civil Monetary Penalty

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

CMHC - Community Mental Health Center of East Central Georgia

CNA - Certified Nurse Aide

CPT - Current Procedural Terminology

CRIPA - Civil Rights of Institutionalized Persons Act

DME - Durable Medical Equipment

DOJ - The Department of Justice

DRG - Diagnosis Related Group

DSH - Disproportionate Share Hospital

EOUSA - Executive Office for the United States Attorneys

FBI - Federal Bureau of Investigation

FCA - False Claims Act

FDA - Food and Drug Administration

FEHBP - Federal Employees Health Benefits Program

FFS - Fee -for -service

FUL - Federal Upper Limit

GPO - Group Purchasing Organization

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

HHS - The Department of Health and Human Services

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

HI - Hospital Insurance Trust Fund

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

HIV - Human Immunodeficiency Virus

HPMP - Hospital Payment Monitoring Project

Medi-Medi - Medicare/Medicaid Data Matching Program

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

NHCAA - National Health Care Anti-Fraud Association

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

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

ONC - Office of the National Coordinator for Health Information Technology

PERM - Program Error Rate Measurement

The Program - The Health Care Fraud and Abuse Control Program

SCHIP - State Children's Health Insurance Plan

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

SMP - Senior Medicare Patrol

UPL - Upper Payment Limit

USAO - United States Attorney's Office