The Department of Health and Human Services
And
The Department of Justice
Health Care Fraud and Abuse Control Program
Annual Report For FY 2001

April 2002

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General Note: All years are fiscal unless otherwise noted in the text.

EXECUTIVE SUMMARY

The detection and elimination of health care fraud and abuse is a top priority of Federal law enforcement. Our efforts to combat fraud were consolidated and strengthened considerably by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). 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. The fifth year of operation under the Program saw a continuation of the collaborative efforts of Federal and state enforcement and oversight agencies to identify and prosecute the most egregious instances of health care fraud, to prevent future fraud or abuse, and to protect program beneficiaries.

Monetary Results

In 2001, the Federal government won or negotiated more than $1.7 billion in judgments, settlements, and administrative impositions in health care fraud cases and proceedings. As a result of these activities, as well as prior year judgments, settlements, and administrative impositions, the Federal government collected more than $1.3 billion. More than $1 billion of the funds collected and disbursed in 2001 were returned to the Medicare Trust Fund. An additional $42.8 million was recovered as the Federal share of Medicaid restitution. This is the largest return to the government since the inception of the Program.

Enforcement Actions

Federal prosecutors filed 445 criminal indictments in health care fraud cases in 2001. A total of 465 defendants were convicted for health care fraud-related crimes in 2001. There were also 1,746 civil matters pending, and

188 civil cases filed in 2001. HHS excluded 3,756 individuals and entities from participating in the Medicare and Medicaid programs, or other federally sponsored health care programs, most as a result of convictions for crimes relating to Medicare or Medicaid, for patient abuse or neglect, or as a result of licensure revocations. This record number of exclusion actions is the result of successful collaboration with state Medicaid Fraud Control Units (MFCUs) and state licensure boards.

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 2001

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

STATUTORY BACKGROUND

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

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

As stated above, the Act appropriates monies from the Medicare Trust Fund to an expenditure account, called the Health Care Fraud and Abuse Control Account (the Account), in amounts that the Secretary and Attorney General jointly certify as necessary to finance anti-fraud activities. The maximum amounts available for certification are specified in the Act. Certain of these sums are to be available only for activities of HHS/OIG, with respect to Medicare and Medicaid programs. In 2001, the Secretary and the Attorney General certified $181 million for appropriation to the Account. A detailed breakdown of the allocation of these funds is set forth later in this report. These resources generally supplement the direct appropriations of HHS and the Department of Justice (DOJ) that are devoted to health care fraud enforcement, though they provide the sole source of funding for Medicare and Medicaid enforcement by HHS/OIG. (Separately, the Federal Bureau of Investigation (FBI) received $88 million from HIPAA which is discussed in the Appendix.)

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

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

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

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

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

This annual report fulfills the above statutory requirements.

MONETARY RESULTS

As required by the Act, HHS and DOJ must detail in this Annual Report the amounts deposited and appropriated to the Medicare Trust Fund, and the source of such deposits. In 2001, as a result of the combined anti-fraud actions of the Federal and state governments and others, the Federal government collected a record high of more than $1.3 billion in connection with health care fraud cases and matters.[(3)] These funds were deposited with the Department of the Treasury and the Centers for Medicare and Medicaid Services (CMS) (formerly known as the Health Care Financing Administration, HCFA), transferred to other Federal agencies administering health care programs, or paid to private persons. The following chart provides a breakdown of the transfers/deposits:

Total Transfers/Deposits by Recipient 2001	
Department of the Treasury	
HIPAA Deposits to the Medicare Trust Fund	
Gifts and Bequests	$0
Amount Equal to Criminal Fines	2,894,234
Civil Monetary Penalties	6,060,481
Amount Equal to Asset Forfeiture *	0
Amount Equal to Penalties and Multiple Damages	454,615,907
Centers for Medicare and Medicaid Services	
OIG Audit Disallowances - Recovered	124,450,000
Restitution/Compensatory Damages	662,398,030
Restitution/Compensatory Damages to Federal Agencies	
Office of Personnel Management	8,078,116
Department of Defense	11,264,448
Other Agencies	7,615,320
Department of Health and Human Services - Other than CMS	4,165,252

Relators' Payments **	83,335,798
TOTAL ***	**1,364,877,586**

*This includes only forfeitures under 18 United States Code (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. sec 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, U.S.C. (relating to health care fraud);

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

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

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

HIPAA requires an independent biannual review of these deposits by the General Accounting Office (GAO). The GAO review covering Fiscal Years 2000 and 2001 is ongoing.

PROGRAM ACCOMPLISHMENTS

Expenditures

In the fifth year of operation, the Secretary and the Attorney General certified $181 million as necessary for the Program. The following chart gives the allocation by recipient:

2001 ALLOCATION OF HCFAC APPROPRIATION (Dollars in thousands)	
Organization	**Allocation**
Department of Health and Human Services	
Office of Inspector General (4)	130,000
Office of the General Counsel	3,876
Administration on Aging	1,500
Centers for Medicare and Medicaid Services	2,552

Assistant Secretary for Budget, Technology and Finance	500
Total	138,428
Department of Justice	
United States Attorneys	24,244
Civil Division	16,810
Criminal Division	1,093
Civil Rights Division	609
Justice Management Division	713
Total	43,469
Total	**181,897**

Accomplishments

2001 marked the fifth year of the Program. During those five years, the Program's accomplishments have been impressive. Over $2.9 billion has been returned to the Medicare Trust Fund. In 1999, the Trustees of the Medicare Trust Fund extended their estimate of the financial life of the fund by 30 years. One of the primary contributing factors cited by the Trustees was "the continuing efforts to combat fraud and abuse." (Trustees Annual Report, 1999). Returns to the Federal government as a whole are even larger, over $3 billion. In addition, more than 2,000 defendants were convicted for health care fraud-related offenses. Over 15,000 entities or individuals were excluded from participating in Medicare, Medicaid and other federally sponsored health care programs. The Healthcare Integrity and Protection Data Bank is "up and running" and industry guidance and beneficiary outreach have been greatly expanded. These continuing accomplishments of DOJ and HHS and other partners in the coordinated anti-fraud effort, as well as the extensive preventive activities, demonstrate that the increased funds to address health care fraud and abuse are sound investments.

Collections

During this year, the Federal government won or negotiated more than $1.7 billion in judgments, settlements, and administrative impositions in health care fraud cases and proceedings. As a result of these activities, as well as prior year judgments, settlements, and administrative impositions, the Federal government collected $1.3 billion in cases resulting from health care fraud and abuse, of which more than $1 billion was returned to the Medicare Trust Fund, and $42.8 million was recovered as the Federal share of Medicaid restitution. It should be emphasized that some of the judgments, settlements, and administrative impositions in 2001 will result in collections in future years, just as some of the collections in 2001 are attributable to actions from prior years.

Judgments/Settlements

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

- **HCA - The Healthcare Corporation (HCA).** Formerly known as Columbia/HCA, HCA, the largest for-profit hospital chain in the United States, agreed to plead guilty to criminal conduct and paid over $840 million in criminal fines and civil penalties to the Federal government and the affected states related to five areas of Medicare and Medicaid fraud. This investigation was the largest multi-agency investigation of a health care provider ever undertaken by the government.

  Under the terms of the plea agreement, two subsidiaries - Columbia Homecare Group, Inc. and Columbia Management Companies, Inc. - paid more than $95 million in criminal fines and pleaded guilty to several charges involving a wide range of criminal conduct which occurred at HCA's hospitals nationwide. The criminal conduct charged included cost report fraud, fraudulent billing of Medicare for personnel who worked at home health agencies and other personnel who worked at wound care centers, fraudulent billing to Medicare for patients diagnosed with pneumonia, paying kickbacks and other remuneration to doctors to induce referrals, paying kickbacks in connection with the purchase and sale of

home health agencies, and fraudulent billing of Medicare for fees paid to manage those agencies.

HCA also paid over $745 million to resolve the civil allegations which included: upcoding of pneumonia and other diagnosis-related groups, hospital laboratory tests, overbilling arising from a series of acquisitions of home health agencies, charging marketing costs as home health community education, and billing for non-covered home health services. As part of the civil settlement, HCA entered into a comprehensive 8-year corporate integrity agreement (CIA), and agreed to divest itself of a hospital subject to exclusion.

- **Vencor, Inc.,** one of the nation's largest operators of nursing homes and long term hospital services, agreed to pay the Government a total of $219 million of which $104.5 million resolved civil claims that Vencor knowingly submitted false claims to Medicare, Medicaid, and TRICARE, the military's health care program. This civil settlement concluded a successful joint investigation and negotiation by multiple Federal and state agencies, and represented the largest settlement under the civil FCA to date based on failure to provide adequate health care at long term care facilities. The company entered a 5-year CIA that requires Vencor to adopt a comprehensive quality assurance infrastructure at all levels. Importantly, the government proceeded against Vencor even after the company filed for bankruptcy, stating that the long term care institutions "care for our nation's most vulnerable citizens" and will be held accountable, notwithstanding bankruptcy proceedings.

- **LifeScan, Inc**. Culminating from a cooperative effort among the Food and Drug Administration (FDA), DOJ and HHS/OIG, the United States entered into a global settlement for $60 million with LifeScan, a California corporation that develops, designs, manufactures, distributes and sells blood glucose monitoring systems. The company allegedly marketed an adulterated and misbranded medical device for which Federal (including Medicare, U.S. Department of Veterans Affairs (VA), and TRICARE) and state health care programs paid. The company also pleaded guilty to a misdemeanor violation of FDA laws. To guard against future compliance problems, the government included in the Special Conditions of Probation a requirement that for the next 3 years the company conduct extensive training and internal reviews, and report on these activities. A separate 3-year CIA was also negotiated.

- **Quorum Health Group, Inc**. The owner of 30 acute care hospitals and manager of over 200 more, settled a case for $87.5 million for allegedly engaging in fraudulent cost reporting practices in violation of the FCA. The provider used "reserve" cost reports to determine its allowable Medicare costs and then filed a separate set of allegedly fraudulent cost reports to obtain greater Medicare reimbursement. Quorum's successor, Triad, also entered a comprehensive 5-year CIA.

These and other settlements reflect the culmination of investigations that have been ongoing for several years. Though settled in 2001, the fines and restitution generated by some of these cases will not be credited to the Medicare Trust Funds until 2002.

Highlights of Other Collaborative Efforts

Nursing Homes

One area in which collaboration has proved most effective has been in enforcement and oversight of fraud and abuse in skilled nursing facilities, particularly issues relating to quality of care in these facilities, as demonstrated by the following:

- **Forensics Roundtable.** The DOJ hosted a roundtable discussion of elder abuse and neglect. The roundtable, entitled "Elder Justice: Medical Forensic Issues Relating to Elder Abuse and Neglect," brought together 27 preeminent experts to discuss medical, legal and organizational issues concerning elder justice. The panel of 27 experts represented a variety of professions and areas of expertise, including geriatrics, forensic pathology, family medicine, psychiatry, pediatrics, gerontology, nursing, social work, psychology, emergency medicine, adult protective services, and Federal, state, and local law enforcement. The discussion focused on four distinct but overlapping subjects relating to elder abuse and neglect: (1) detection and diagnosis, (2) application of forensic science, (3) education and training, and (4) research. A consensus emerged that an inadequate research base, lack of education, insufficient coordination, and poor planning nationwide have made it difficult to prevent, detect, diagnose, intervene, treat, and prosecute elder abuse and neglect. More information about the roundtable, including the recommendations for follow-up, may be found at: *http://www.ojp.usdoj.gov/nij/elderjust/index.html*

- **Enforcement Actions.** Several important enforcement actions against nursing homes also culminated in 2001, including the Vencor case, described above, and the following**:**

- **Questionable Nursing and Therapy Services Charges:** National Healthcare Corporation (NHC) entered a $27 million civil settlement to resolve allegations that the company submitted inflated Medicare costs reports. The government alleged that the cost reports overstated the number of hours that the nursing staff spent caring for Medicare patients, and that some nursing home personnel were billed as performing therapy on Medicare patients which were not performed. As a condition of the settlement of this case, NHC also entered a 5-year CIA.

- **Owner of Nursing Home Excluded:** The principal operator and co-owner of two nursing homes and other health care businesses in Pennsylvania agreed to a 5-year exclusion for his role in providing substandard physical, medical and personal care to residents of those homes. The settlement represents the first time HHS/OIG has excluded the owner of a health care facility based on the owner's responsibility for poor quality of care at the facility.

- **Heightened Monitoring of Quality of Care**: Manor Care, Inc., and affiliates, settled a civil FCA case arising from alleged inadequate care to Medicare patients residing at one of the corporation's skilled nursing facilities. The government contended that the quality of patient care was substandard, including inadequate nursing care for residents with pressure ulcers, insufficient staffing, training and supervision, and missing or incomplete assessments of residents' functional capacity and needs. Under the consent order and judgment, the company will pay $90,000 to the government. More importantly, the company is required to retain an independent consultant and take other steps to closely monitor future quality of care at the facility. To ensure compliance, the approving Court specifically retained jurisdiction until the corporation fully implements all provisions of the extensive order.

- **Criminal Convictions for Bribery:** A former official of the Oklahoma State Department of Health and an Oklahoma nursing home owner were sentenced to three years in prison and ordered to pay $50,000 in fines. Both were convicted of bribery in violation of 18 U.S.C. ï¿½ 666. Under the scheme, the owner agreed to pay the Deputy Commissioner a bribe in return for the Deputy Commissioner's aid in falsifying and backdating documents relating to Medicare reimbursements to the nursing home company. The investigation was conducted by the FBI, HHS/OIG and the Oklahoma State Attorney General's MFCU.

- **Grants by DOJ.** During 2001 DOJ awarded grants to organizations for follow-up work based on the Forensic Roundtable, and other projects, for the following purposes:

  - To establish a working group of experts to identify, review, refine, and develop priorities among the myriad of suggestions made at the Roundtable. One objective of the working group will be to gather information from Federal agencies and national, state, and local organizations about contemplated, planned or existing activities related to medical forensic aspects of elder abuse and neglect, in order to promote communication and coordination and to identify promising practices.

  - To provide five community organizations with funds to address elder victimization issues at the community level, such as coordination and referral to law enforcement.

  - To provide a statistical analysis and report of current data concerning local prosecutions for nursing home abuse and neglect and other types of elder victimization and a survey of local prosecutors to identify needs and priorities in pursuing these cases.

  - To develop and empirically demonstrate the signs of abuse, and to gain a further understanding of bruising (location, coloration, and resolution) in the geriatric population.

  - To identify and describe the forensic markers for elder sexual abuse that will be used to develop a database critical for understanding how intentional sexual injuries may present in the geriatric population.

- **Recommendations to Improve Quality of Care**. The HHS/OIG issued several significant reports assessing a variety of facets of nursing home care. In a study of Medicare reimbursement for therapy services, significant levels of error were found in physical, occupational, and speech therapy services to Medicare nursing home patients. Medicare erroneously paid approximately $48.5 million for medically unnecessary, undocumented and inadequately documented therapy during the first half of 1999. This represented a disturbing overall error rate of 24.7 percent. Enhanced provider education, and focused medical reviews were recommended to reduce the error rate.

In addition, HHS/OIG evaluated current practice in implementing the nursing home resident assessment and concluded that inability to validate the resident assessment through the medical record exposes the Medicare program to billing abuses. The HHS/OIG also examined safeguards that ensure the appropriate admission and mental health treatment of younger Medicaid beneficiaries who have a serious mental illness and reside in nursing facilities, and found that the required pre-admission screening and resident reviews are not in compliance with Federal requirements.

Technology

CMS and DOJ cosponsored a national conference, Combating Health Care Fraud & Abuse: Technologies and Approaches for the 21st Century, which explored technologies and approaches used to detect, prevent, and investigate health care fraud and abuse in Federally-funded health programs in June 2000. At the conference, interactive regionally-based group working sessions produced recommendations for specific follow-up action, which CMS and DOJ developed into an Action Plan for the future. The final report and Action Plan were released in May 2001. Chief among these recommendations was formation of a National Technology Group to consist of representatives from Federal and state health care program integrity and law enforcement agencies. The group was formed, and held its first meeting in June of 2001. The group will address national issues that crosscut Federal and state health care program and law enforcement agencies, provide policy and operational guidance, serve as an information clearinghouse for the use of fraud detection technology and collaborative program integrity and enforcement approaches, and seek to facilitate formation and coordination of Regional Technology Users' Group.

Drug Pricing

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

- **CIA Requiring Medicaid Price Reporting:** A settlement was finalized with the Bayer Corporation, with the company agreeing to pay the Government $14 million and to enter a 5-year CIA. At issue were the average wholesale prices that Bayer reported for six of its drugs, and alleged misrepresentations that Bayer made to state Medicaid programs and to CMS. The CIA is noteworthy because, for the first time, a company agreed to affirmatively report certain drug pricing information, including an obligation to provide certified pricing data directly to the Medicaid programs for covered Bayer products.

- **Settlement in Connection with Partially Filled Prescriptions:** The DOJ and HHS/OIG, working jointly with representatives of the MFCUs, reached settlement in a *qui tam* action against CVS Corporation, involving allegations that the company submitted claims for partially-filled prescriptions to Medicaid, TRICARE and the Federal Employee Health Benefits Program (FEHBP). In addition to paying $4 million to the government, CVS also agreed to a 4-year CIA.

Status of Medicare and Medicaid Drug Pricing and Payment

Medicaid-Pharmacy Acquisition Costs: Ongoing audits and evaluations have generated information that will be valuable to policymakers who are considering alternate reimbursement approaches. Following up on previous work, HHS/OIG conducted a nationwide review of pharmacy acquisition costs for brand name drugs reimbursed under Medicaid. Most states use average wholesale price (AWP) minus a percentage discount, which varies by state, as a basis for reimbursing pharmacies for drug prescriptions. This review sought to determine the size of the discount. Based on pricing information from 216 pharmacies in 8 States, HHS/OIG estimated that the national actual acquisition cost for brand-name drugs was an average of 21.8 percent below AWP. In most states, the average discount below AWP for reimbursement of estimated acquisition cost was only 10.3 percent in 1999. If this disparity were eliminated, HHS/OIG estimated that nearly $1.1 billion could have been saved for the 200 brand name drugs (accounting for the greatest amount of Medicaid reimbursement in 1999).

Medicare-inflated Payments for Prescription Drugs: In Medicare, HHS/OIG studies spanning the last 4 years have revealed that Medicare and its beneficiaries pay considerably more than do other Federal health care programs for prescription drugs. In January 2001, HHS/OIG released a report comparing Medicare reimbursement to prices available to the physician/supplier community, the Department of Veterans Affairs (VA), and to Medicaid. The study focused on 24 drugs representing $3.1 billion of the $3.9 billion in Medicare drug expenditures in 1999. For every drug in the review, Medicare paid more than the wholesale price available to physicians and suppliers and the VA Federal Supply Schedule price. In fact, for half of the drugs, Medicare paid

more than double the VA price. Medicare and its beneficiaries would have saved over $1.6 billion if it had paid the same amount as does the VA, or $761 million at actual wholesale prices. These comparisons were run again using more current drug pricing information -- the sometimes large discrepancies between Medicare and other reimbursement for the same drugs remained. The study also found that Medicare carriers are not establishing consistent drug reimbursement amounts for certain drugs. The HHS/OIG recommended that CMS continue to seek administrative and legislative remedies to reduce excessive drug reimbursement amounts and require all carriers to reimburse a uniform amount for each drug.

Medicaid Rebates: Medicaid reimburses pharmacies and other providers for the drugs that they dispense to Medicaid beneficiaries. Manufacturers must pay rebates, shared between states and the Federal government, on all drugs sold to Medicaid. The rebate is based on the difference between best price and Average Manufacturers Price (for sole source drugs) or a statutory percentage of the Average Manufacturer Price (for generic drugs). "Best price" is defined as the lowest price at which drug manufacturers sell drugs to any non-governmental, for-profit purchaser and specifically includes sales to health maintenance organizations (HMOs). CMS guidance permits the exclusion of sales to drug repackagers in calculating the best price. However, this follow-up review confirmed that manufacturers were excluding sales to repackagers from their best price, even when the repackagers were HMOs. CMS guidance does not permit the exclusion of sales to repackagers if the "repackager" is not actually reselling the drug, i.e., is, instead, "selling" the drug to a subsidiary or affiliate - in effect keeping the drugs for its own use. As a result, the Medicaid program lost drug rebates totaling $80.7 million. The HHS/OIG recommended that CMS require drug manufacturers, who excluded sales to HMOs from their best price determinations, to repay the lost rebates. CMS concurred, and intends to revisit policies on exclusion of sales from best price determinations.

Pharmacy Payments from Third Parties: Millions of Medicaid beneficiaries have other pharmacy coverage through private health plans, employers, non-custodial parents, State programs such as workers' compensation, or Federal programs such as Medicare. Because Medicaid is usually considered the payer of last resort, other insurance sources may be liable for claims providers send to Medicaid. An HHS/OIG study found that States were at risk of losing 80 percent ($367 million) of the payments they tried to recover ($440 million) in 1999 through a "pay and chase" approach. On the other hand, States that did not make the unnecessary payments in the first place safeguarded $185 million against possible risk. Almost three-quarters of States surveyed reported that third parties refuse to process or pay Medicaid pharmacy claims. States say they have more problems with pharmacy benefit management companies than with all other types of third parties combined. The $367 million represents the universe of potentially recoverable claims. In those states where financial records were reviewed, the amount actually recoverable is somewhat less due to coverage and eligibility requirements of third party payers that are not known to States. The CMS concurred with HHS/OIG recommendations to review use of cost avoidance waivers (which authorize Medicaid to pay first and seek reimbursement from private insurers), improve claim formats, and educate third party payers.

Program Exclusions

There was another significant rise in the number of individuals and entities excluded from doing business with Medicare, Medicaid and other Federal and state health care programs. Exclusions in 2001 were at a record high. A total of 3,756 individuals and entities were excluded from participation in Federal programs. This is a 12.1 percent increase from 3,350 exclusions in 2000.

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

FUNDING FOR DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General

Certain of the funds appropriated under HIPAA are, by statute, set aside for Medicare and Medicaid activities of HHS/OIG. During the fifth year of the Program, the Act provided that between $120 and $130 million be devoted to these purposes. The Secretary and the Attorney General jointly allotted $130 million to HHS/OIG in 2000, an increase of $10.75 million over 1999.

HHS/OIG conducted or participated in 840 prosecutions or settlements in 2001, of which 664, or 79 percent, were health care cases. A total of 3,756 individuals and entities were also excluded, many as a result of criminal convictions for crimes related to Medicare or Medicaid (682); or to other health care programs (66); for patient abuse or neglect (309); or as a result of licensure revocations (1,846). This all time high in exclusion actions is the result of increased outreach and collaboration with State licensing boards and MFCUs.

In addition to HHS/OIG's role in bringing about the judgments and settlements described in the Overview of Accomplishments, HHS acted on HHS/OIG recommendations and disallowed $124.45 million in improperly paid health care funds in 2001. HHS/OIG continues to work with CMS to develop and implement recommendations to correct systemic vulnerabilities detected during HHS/OIG evaluations and audits. These corrective actions often result in health care funds not expended (that is, funds put to better use as a result of implemented HHS/OIG initiatives). In 2001, such funds not expended amounted to more than $16 billion -- nearly $13 billion in Medicare savings, and $3.1 billion in savings to the Medicaid program.

Fraud and Abuse Prevention

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

- **Industry Guidance.** The centerpiece of the HIPAA guidance initiatives was an advisory opinion process through which parties would obtain binding legal guidance as to whether their existing or proposed health care business transactions ran afoul of the Federal anti-kickback statute, the civil monetary penalties laws, or the exclusion provisions. During 2001, HHS/OIG issued 21 opinions. A total of 66 advisory opinions have been issued since 1997. The advisory opinion process serves to enhance HHS/OIG's understanding of new and emerging health care business arrangements and informed the development of new safe harbor regulations, fraud alerts, and special advisory bulletins.

- **Corporate Integrity Agreements**. Many health care providers that enter agreements with the government in settlement of potential liability for violations of the FCA also agree to adhere to a separate CIA. Under this agreement, the provider commits to establishing a program or taking other specified steps to ensure its future compliance with Medicare and Medicaid rules. The duration of most CIAs is 5 years, during which time the provider must submit periodic reports to HHS/OIG. These agreements require a substantial effort by the provider to ensure that the organization is operating in accordance with Federal health care program requirements and the parameters established by the CIA. At the close of 2001, HHS/OIG was monitoring more than 300 CIAs.

- **Compliance Roundtable**. In July 2001, HHS/OIG and the Health Care Compliance Association cosponsored a Roundtable discussion to afford providers and other entities an opportunity to talk directly with HHS/OIG officials about compliance programs subject to CIAs. The meeting offered HHS/OIG an opportunity to describe its CIA policy objectives and receive providers' unique insights on ways to accomplish these objectives without unnecessary burden on the providers. Over 50 health care providers and 30 Government representatives took part in group discussions on topics that ranged from compliance education and training, and compliance program infrastructure, to audit requirements and reporting to HHS/OIG. Participants from both industry and government exchanged ideas about how best to work together to protect the integrity of the health care system. In a related effort to obtain feedback on implementation and maintenance of compliance programs and CIAs, HHS/OIG also distributed a survey to providers that were, at the time, operating under CIAs. The survey sought information relating both to the substance of CIA requirements (such as independent review organizations, confidential disclosure programs, claims review, and reporting) as well as the responsiveness and professionalism of HHS/OIG's oversight. The results of both the survey and the Roundtable will provide valuable information to the HHS/OIG as it reexamines and reforms the CIA process. More information on the results of the survey may be found at *https://oig.hhs.gov/*.

  In response to feedback received from the Provider Roundtable and the survey of providers subject to CIAs, the HHS/OIG developed a plan to modify its role in the civil settlement process. First, the HHS/OIG

developed criteria for the provider community as to those situations which would not require a CIA to resolve a provider's liability under the FCA. Second, the HHS/OIG modified the claims review procedures contained in CIAs, and revised the CIA requirement with respect to the use of independent review organizations. Both changes are intended to reduce the financial impact of these requirements without weakening the integrity of a provider's compliance program. These modifications will be offered both to providers which negotiate future CIAs, as well as those with existing CIAs.

- **Medicare Error Rate:** The HHS/OIG reported that improper payments under Medicare's fee-for-service system totaled an estimated $11.9 billion during 2000. That estimate was the lowest to date and about half of the $23.2 billion that was estimated for 1996, when HHS/OIG developed the first national error rate. The HHS/OIG developed the estimate of improper payments with the support of medical experts who together reviewed a comprehensive statistical sample of Medicare fee-for-service claims expenditures and supporting medical records to determine the accuracy and legitimacy of the claims.

  The HHS/OIG believes that since the first error rate of 1996, CMS has demonstrated continued vigilance in monitoring the error rate and developing corrective action plans. Clearly these corrective actions have been successful. The majority of health care providers now submit claims to Medicare for services that are medically necessary, billed correctly, and documented properly. As in past years, HHS/OIG estimated that over 90 percent of the 2000 fee-for-service payments met Medicare reimbursement requirements. The HHS/OIG's 5-year analysis indicates that over 70 percent of the claims that did not meet reimbursement requirements were attributable to unsupported and medically unnecessary costs - two areas that will receive ongoing monitoring.

- **Recommendations for Systemic Improvements:** Frequently, investigations, audits and evaluations reveal vulnerabilities or incentives for questionable or fraudulent financial practices in agency programs or administrative processes. As required by the Inspector General Act, HHS/OIG makes recommendations to address these vulnerabilities, and thereby promote economy and efficiency in HHS programs and operations. Relying on the independent factual information generated by HHS/OIG, agency managers recommend legislative proposals or other corrective actions that, when enacted or implemented, close loopholes and reduce improper payments or conduct. The net savings from these joint efforts toward program improvements can be substantial. Many of the studies described throughout this report offered evidence and ideas supporting proposals for significant cost savings during 2001 and beyond. Prominent examples of these reviews include the following:

  - **Upper Payment Limit (UPL)**. States are allowed to pay Medicaid facilities above their cost for a service or procedure, as long as the State's aggregate payment does not exceed the amount that would have been paid under Medicare (referred to as the upper limit). In a series of audits, HHS/OIG has found that some States use intergovernmental transfers as a financing mechanism to maximize Federal Medicaid reimbursement available through UPLs, and effectively avoid contributing the state share of Medicaid spending. Over the past year, CMS has published three final regulations to curb states' use of this loophole. The CMS estimates that the new rules will save $77 billion in Federal Medicaid funds over the next 10 years.

  - **Therapy**. The Balanced Budget Refinement Act of 1999 suspended Medicare reimbursement caps on Part B physical, occupational, and speech therapy that were imposed in 1997. The monetary caps on services coincided with a dramatic decrease in Part B therapy charges during 1999. Preliminary reports indicate that there was a rebound in Skilled Nursing Facility therapy charges in 2000 and 2001. An HHS/OIG study indicated that this rebound is attributable both to the moratorium on caps and perceived inadequate contractor oversight of billing practices and medical necessity of Part B therapy. In response, CMS will take steps to ensure that adequate medical reviews of Part B therapy are conducted and to improve providers' understanding of guidelines for Part B therapy and billings.

  - **UPIN**. An evaluation of Unique Physician Identification Numbers (UPINs) revealed a fundamental vulnerability in Medicare's claims payment process -- one that can easily be corrected. The report found that in one year, Medicare paid over $90 million for medical equipment and supply claims with invalid or inactive UPINs. Moreover, a small number of suppliers accounted for a significant share of these charges. The HHS/OIG recommended that CMS revise claims processing to ensure that claims contain UPINs that are valid and active. As HIPAA requires CMS to establish unique identifiers for all health care providers, this report recommended that CMS take steps to validate and update UPIN Registry data prior to implementation of the new provider identifier system

- **Payments for Mental Health Services:** A study of Medicare payments for mental health services revealed that 39 percent of psychiatric services in nursing homes were medically unnecessary, had no mental health documentation or were questionable. An area of particular vulnerability was psychological testing; nearly one-third of the tests were too frequent, medically unnecessary, or utilized questionable testing instruments. CMS has agreed to develop guidelines in these areas, which will both protect the quality of mental health services and could result in a potential savings of $30 million a year.

  In a separate study, HHS/OIG found that Medicare allowed $185 million in 1998 for outpatient mental health services that were medically unnecessary, billed incorrectly, rendered by unqualified providers, and undocumented or poorly documented. CMS has agreed to take steps to identify problematic mental health services for prepayment edits or post-payment medical review, promote awareness of documentation and medical necessity requirements, further refine guidance on a particular testing code, and require carriers to initiate recovery of payments for the inappropriate outpatient mental health services identified in the report.

- **Duplicate Payments.** An HHS/OIG evaluation of 15 procedure codes found that Medicare's claims processing system permitted duplicate payments by more than one carrier. Total improper payments for the sample services were approximately $446,000. HHS/OIG recommended that CMS either revise Common Working Files edits to detect and deny duplicate billings, or, if more cost effective, increase post-payment reviews. A related study disclosed 3,152 services involving potential duplicate payments made by the same carrier, resulting in estimated questionable allowances of approximately $2.25 million. Other potential duplicate payments were found involving over 2,000 other procedure codes. CMS has agreed to investigate its claims processing systems to determine why potential duplicate services were not detected and to recover improper payments.

Focus on Quality of Care

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

Enforcement Actions:

- A physician convicted twice in Florida was excluded from Medicare and other health care programs for 25 years for practicing medicine without a license, and later for executing a scheme for obtaining fraudulent medical school documents which he used to secure a license. He then represented himself to be a qualified and validly licensed physician and billed health care programs through the mail for services he provided to patients. The court ordered him jailed for 39 months and to pay almost $5 million in restitution.

- The owner of an Illinois business providing counseling services was sentenced to more than three years incarceration and required to pay $6.7 million in restitution for submitting false claims for group psychotherapy sessions that either never occurred or were conducted by unlicensed personnel. To bill for these sessions, the owner used the Medicare provider numbers of licensed clinical social workers, physicians and other mental health professionals without their knowledge.

- An Indiana woman was convicted of mail fraud for having forged two occupational therapy licenses for her own use after taking copies of actual licenses from a local hospital. For over two years, the woman, who had no medical training, worked in an Indiana nursing home treating disabled Medicare beneficiaries. The costs of her salary and the services she provided were ultimately billed through the nursing home's cost report and paid by the Medicare program. This criminal case resulted from the HHS/OIG Self-Disclosure Program.

- The owner of a now defunct Durable Medical Equipment (DME) company was convicted for paying $85,000 in kickbacks to induce a physician to order wound care supplies billed to Medicare. The individual also violated misbranding rules of the FDA through his ownership of a company that manufactured hydrogel wound care dressings which were labeled and packaged as "sterile" but were not actually tested for sterility. In an earlier civil

settlement, the former owner agreed to pay the Government $255,000 and accepted a 15-year exclusion from Federal health care programs.

Patient Anti-Dumping Enforcement. HHS continues to pursue potential violations under the Emergency Medical Treatment and Labor Act, also called the patient anti-dumping statute. In 2001, HHS/OIG obtained 21 settlement agreements and judgments with hospitals and physicians and collected civil monetary penalties of nearly $437,750. This reflects the continued commitment of both CMS and HHS/OIG to ensure patient access to appropriate emergency medical services.

Other Judgments and Settlements. In addition to the significant enforcement actions described in the Program Accomplishments section of this report, the HHS/OIG conducted or participated in over 664 investigations that resulted in prosecution or settlement during 2001, involving all aspects of the health care industry. These include:

- Prescription Drug Fraud. The HHS/OIG worked with the DOJ Drug Enforcement Administration and State and local authorities to investigate fraudulent diversion and "street" sale of prescription drugs such as OxyContin. These schemes often involve patients, beneficiaries, pharmacists, physicians and others who obtain prescription drugs, reimbursed by Medicaid, under false pretenses for personal use or for resale. One such investigation in Maine has already resulted in 19 guilty pleas for health care fraud and related offenses.

  In another matter, the chief of the radiology department at a Virginia hospital was sentenced for acquiring a controlled substance by misrepresentation, fraud, forgery, deception and subterfuge. From June 1998 through January 1999, the radiologist accessed the hospital's pharmaceutical cabinet and diverted morphine and fentanyl for his own use over 175 times. To conceal this diversion, he created charge tickets indicating that the drugs were for patients undergoing invasive procedures. Because many of the patients were Medicare beneficiaries, the program was inappropriately billed for pharmaceuticals taken under false pretenses.

  A third physician was sentenced to more than 10 years for conspiracy to dispense and distribute controlled substances and for Medicare fraud and kickbacks, and was ordered to pay $229,384 in restitution. The indictment alleged that the physician routinely wrote large quantities of prescriptions for highly addictive pain medication, billed Medicare for services not provided and upcoded office visits. A pharmacy owner was convicted in the same scheme, and sentenced to serve 16 years imprisonment and fined $56,400 for drug-related offenses. Through his pharmacy, the individual dispensed in excess of one million doses of highly addictive pain medication based upon prescriptions written by the physician. Furthermore, the individual knowingly filled hundreds of invalid prescriptions that the physician had prewritten and which contained false information.

- **Kickbacks and Patient Brokering.** In 2001, ten individuals including four who were principal owners of the largest illegal patient brokering network in the United States were sentenced in Florida. From 1989 through 1997, the company engaged in the business of supplying patient referrals to inpatient psychiatric hospitals for up to $6,000 per patient. The company acquired patient referrals, including Medicare beneficiaries, by paying kickbacks to referral sources. To disguise the patient referral fees as legitimate services, the company created false contracts and agreements with the hospitals. The investigation is ongoing.

  In a separate matter, a total of 31 defendants were indicted in a Medicare fraud and kickback scheme investigated by a joint health care fraud task force in Florida. Owners of a DME company and clinic and their associates allegedly recruited Medicare beneficiaries involved and used their Medicare numbers to bill the program for equipment not provided. The beneficiaries also signed fraudulent delivery receipts for the equipment in return for kickbacks in cash, checks or food. To date, 10 of the 31 individuals charged in connection with this investigation have pled guilty.

Office of the General Counsel

In 2001, the Office of the General Counsel (OGC) was allocated $3.8 million in funding from HCFAC. These funds were used primarily for litigation activity, both administrative and judicial.

Accomplishments

Initiatives for Preventing Health Care Fraud

- *Stark regulation* - Continuing its work with CMS and HHS/OIG to clarify the prohibitions against self-referrals by physicians to protect beneficiaries and taxpayers from potentially abusive referral patterns, OGC finalized Phase I of the final rule and is working with HHS/OIG and CMS to complete Phase II of the final rule. Phase II gives physicians clear direction about how to structure financial arrangements if they are ordering certain services from a hospital or other entity with which they have a financial relationship.

- *Community Mental Health Center Initiative* - During 2001, OGC provided comprehensive legal assistance to CMS, Region VI, with respect to the planning and unprecedented implementation of a large scale suspension of payments project. Fraudulent physical therapy claims in the Houston, Texas area were being filed for services that were either medically unnecessary or for services that were not actually being provided. OGC provided legal clearance for the coordinated suspension of payments to more than 60 physical therapy clinics in August 2001. To date, none of these suspensions have resulted in any court challenge.

Policy Guidance and Education

- OGC improved the effectiveness of the Nursing Home Oversight and Improvement Program enforcement effort by (1) recommending legislation and submitting comments on draft legislation (ultimately included in the Department's legislative package) to bar Federal court jurisdiction over attempts by Medicaid-only facilities to enjoin HHS enforcement actions; (2) submitting comments and suggested revisions on proposed changes in State Operations Manual; (3) commenting on and suggesting revisions to CMS's model enforcement notice letters; (4) proposing changes to Part 498 of the regulations governing appeals; (5) making presentations to CMS surveyors and enforcement staff, state surveyors and state survey agency attorneys on survey and enforcement issues; and (6) preparing a 160-page digest of all administrative decisions in nursing home enforcement cases, which is now used by CMS and OGC offices nationwide.

- OGC is building on successful partnerships previously established in Wisconsin, Michigan and Ohio, by initiating "Medicare Secondary Payer partnership" discussions with the U.S. Attorney's Offices for the Northern and Southern Districts of Indiana with the Medicare contractors for Indiana. In 2001, OGC secured an agreement in principle and is now working out the details of the partnership arrangements and procedures designed to enhance recovery of conditional Medicare payments in tort cases involving Medicare beneficiaries in the State of Indiana.

Civil and Criminal Enforcement Actions

- *Qui Tam* Covenant Care settlement - In May 2001, the United States resolved allegations of fraud with Covenant Care for $1.6 million. Covenant Care allegedly submitted false claims to Medicare for its nursing homes by improperly allocating hours to the Medicare certified distinct parts of its nursing facilities for nursing services that were actually provided in the non-certified parts of the facilities. OGC's CMS division worked closely with DOJ to calculate the amount of damages and recovered an additional $450,000 for overpayments made to Covenant Care that fell outside the scope of the fraud investigation. This cooperative effort resulted in a significant return to the Medicare trust fund.

- OGC asserted CMS's interests in numerous bankruptcy and receivership actions throughout the country by negotiating agreements to recover overpayments and advancing the use of offset recovery. For example, in Vencor, the court affirmed the plan of reorganization under which the United States will receive $104.5 million under the FCA on behalf of the Medicare Trust Fund, which includes $20.8 million for false claims involving substandard quality of care. Medicare will receive another $92.5 million for other overpayments.

Administration on Aging

In 2001, the Administration on Aging (AoA) was allocated $1.5 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.

Accomplishments

- National Technical Assistance Resource Centers: AoA established and supported four national resource centers to provide materials and technical assistance to aging service professionals for the purpose of educating and empowering vulnerable and culturally diverse older Americans to take a more active role in monitoring and protecting the benefit integrity of Medicare and Medicaid.

- National Videoconference on "Innovative Strategies for Reaching Underserved and Unserved Populations." AoA and its four resource centers convened a national video conference that was linked via satellite to more than 130 community locations in 41 states. The video conference informed thousands of professionals and others who provide services to older Americans about successful strategies for educating minority, rural, and non-English-speaking beneficiaries about Medicare and Medicaid fraud and abuse. The program continues to be distributed via videotapes, and is available on-line through the resource centers' website.

- Regional Partnership and Collaboration Conferences. AoA convened four regional conferences which brought together hundreds of Federal, state, and community partners to share successful products and practices, strengthen collaboration between Federal, state, and local partners, and to work to advance the performance of outcome tracking mechanisms.

- Development of New Website. AoA launched a new website dedicated to information about Medicare and Medicaid fraud and abuse. The purpose of the site is to promote consumer awareness and facilitate the sharing of information and best practices between the agency's partners and grantees, as well as among aging network professionals.

- Distribution of Community Education Materials. HCFAC funding supported the distribution of health care journals in nearly every state in the country, as well as community education brochures in English, Spanish, and Mandarin Chinese. Community education videos in English, Spanish, and Chinese that were developed with HCFAC funding during 2000 were distributed throughout 2001 via AoA's grantees and through the network of state and area agencies on aging.

- Senior Medicare Patrol Projects: AoA provided technical assistance to AoA's 52 Senior Medicare Patrol (SMP) projects, located in 47 states plus the District of Columbia and Puerto Rico. The projects recruit and train retired individuals to educate other seniors in their communities about how they can help prevent and detect potential Medicare and Medicaid error, fraud, and abuse. The SMP projects trained more than 10,000 senior volunteers, in 2001, who directly educated more than 300,000 beneficiaries.

- Other Community Education Activities: An estimated 40 million individuals were also reached through a variety of television, radio, and print media events. While it is not possible to directly track the cases reported and dollars recovered through these community education activities, the projects reported nearly $60 million in Medicare, Medicaid, and other dollars recouped through the complaints they referred, and through their partnership activities.

Centers for Medicare and Medicaid Services

In January 2001, $2.5 million in HCFAC funds was allocated to the Centers for Medicare and Medicaid Services (CMS) to assist states in developing Medicaid payment accuracy

measurements (PAM) methodologies and to conduct pilot studies to measure and reduce state Medicaid payment errors. CMS is also committed to exploring the feasibility of estimating the range of improper Medicaid payments on a national level. The focus of both the state-specific and national efforts is on payment, not eligibility errors (which are governed exclusively by section 1903(u) of the Social Security Act).

The funding was approved for three purposes: (1) to contract for outside technical expertise to assess state, Medicare and other PAM experience to date and develop a national Medicaid methodology; (2) to provide incentive grants to two or three states to conduct PAM studies and assess the feasibility of establishing a standard methodology that might be used by all states; and (3) to hire four analysts in CMS to direct and staff this initiative. CMS proposed to work closely with HHS/OIG, and with the National Association of State Medicaid Directors and its Fraud & Abuse Technical Advisory Group (TAG).

In July 2001, CMS' Center for Medicaid and State Operations invited all state Medicaid and Program Integrity directors to apply for participation in the PAM demonstration project, which is a federally funded, collaborative effort to develop model PAM methodologies for use on a state-specific and national basis. State proposals were solicited under the authority of section 402(a)(1)(J) of the Social Security Act Amendments of 1967. The duration of the project will cover a minimum of two years, with funding approved initially for the first year only.

Accomplishments

- Nine states applied to participate in the PAM pilot: Louisiana, Minnesota, Mississippi, New York, North Carolina, North Dakota, Texas, Washington and Wyoming. Five of these states are represented on the Medicaid Fraud and Abuse Control TAG. On September 26, 2001, CMS approved all nine applications, with an estimated cost to HCFAC of $1.8 million.

- 2002 Plans: the nine states will test various approaches to Medicaid PAM. Most will focus on fee-for-service payments, although Minnesota will address the validation of encounter data, a key element of PAM in the managed care context. In 2002 CMS will solicit participation of up to 15 states in Year Two of the pilot, including potential funding of the initial 9 states. As part of its 2002 efforts, CMS will evaluate the progress of the initial pilots and may continue funding the initial nine states' efforts.

- In September 2001, CMS contracted with The Lewin Group for technical assistance to CMS and the pilot states, at an estimated cost of $.7M for Year One of the pilot. The Lewin Group's experience includes extensive work with CMS in developing Medicare error rate measurement methodologies, as well as relevant studies for a number of states. Lewin will work closely with the Medicaid pilot states, CMS and HHS/OIG to help develop promising PAM methodologies. Lewin will review the literature in this area to glean useful guidance, analyze appropriate statistical approaches, explore how to apply PAM to managed care, and propose standards for reviewing medical records.

Assistant Secretary for Budget, Technology and Finance

At the end of 2001, $500,000 of HCFAC funds were allocated to the Assistant Secretary for Budget, Technology and Finance (ASBTF) to fund certain contractual consultant services related to the Departments's new financial management system. The services entail providing oversight and independent verification and validation of the development of the new system. The contract was awarded in September 2001. The funding covers the requisite consulting services over the four-month period, ending in January 2002.

The CMS Healthcare Integrated General Ledger Accounting System will be a major component of the new HHS integrated financial management system. This system will include Indian Health Service (IHS) financial and health care-related information. The new system will increase HHS managers' accountability, address various material weaknesses at the CMS, strengthen internal controls at IHS, and help prevent waste and abuse in HHS health care programs.

ASBTF is using a consulting company to help ensure that the new integrated financial management system is being developed to meet the Department's financial management goals. Specifically, this HCFAC project is to ensure that the new system will preserve the integrity of the Department's financial information and resulting financial statements and management reports, including Medicare contractor information, CMS financial information, and IHS' unique financial reporting needs that are related to health care payment and delivery

system. Overall, HHS will ensure the new system's compliance with statutory requirements of the Chief Financial Officers Act of 1990, the Federal Financial Management Improvement Act of 1996 and other pertinent laws.

FUNDING FOR DEPARTMENT OF JUSTICE

United States Attorneys

Health care fraud involves a variety of schemes that defraud public and private insurers and providers nationwide. In addition to Medicare and Medicaid, a number of federally funded health benefit programs have been the targets of these schemes. The fraudulent activity may include double-billing schemes, kickbacks, billing for unnecessary or unperformed tests, or may be related to the quality of care provided to patients. In addition to monetary losses, in some instances these improper activities endanger patient safety. United States Attorneys' offices (USAOs) are responsible for civilly and criminally prosecuting health care professionals, providers, and other specialized business entities who engage in health care fraud and abuse.

USAOs continue to strengthen and refine cooperative efforts with Federal, state and local law enforcement agencies involved in the prevention, evaluation, detection, and investigation of health care fraud and abuse. In addition to the FBI, HHS/OIG and CMS, USAOs offices work with State Medicaid Fraud Control Units, Offices of Inspectors General for a number of Federal agencies, the Drug Enforcement Administration, the FDA, the Defense Criminal Investigative Service and the TRICARE Support Office. Each USAO has appointed both a civil and criminal health care fraud coordinator to assist in coordination and to facilitate communication between Federal, state and local law enforcement groups. In addition, many cases are investigated in a parallel fashion, so that potential criminal and civil remedies are addressed more efficiently, by the attorneys and the agencies investigating the wrongdoing. The criminal and civil judgments and settlements discussed in the program accomplishments above were among the many significant accomplishments of the USAOs and are examples of such parallel investigations and prosecutions.

Prior to the enactment of HIPAA, USAOs dedicated substantial resources to combating health care fraud and abuse. HIPAA allocations have supplemented these efforts.

Training

The Executive Office for the United States Attorneys' Office of Legal Education (OLE) is tasked with the responsibility for providing health care fraud training for USAO and DOJ attorneys, investigators, and auditors. During 2001, OLE conducted a number of courses and presentations on health care fraud, including:

1. Basic Health Care Fraud Seminar - Criminal and Civil
2. Advanced Health Care Fraud Seminar - Criminal and Civil
3. Affirmative Civil Enforcement - Special Topics (includes a health care fraud component)
4. Affirmative Civil Enforcement for auditors and investigators (includes a health care fraud component)

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

Accomplishments - Criminal Prosecutions

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

Each time a criminal case is referred to a USAO from the FBI, HHS/OIG, or another law enforcement agency, it is opened as a matter pending in the district. A referral remains a matter until an indictment or information is filed or the case is declined for prosecution. In 2001, the USAOs had 1,791 criminal matters pending involving 2,733 defendants, a 7 percent decrease in the number of criminal matters over 2000. During 2001, 445 cases were filed involving 601 defendants. This represents a 2 percent increase over cases filed in 2001. A total of 465 defendants were convicted for health care fraud-related crimes in 2001. Health care fraud convictions include both guilty pleas and guilty verdicts. A sample of the criminal cases brought by USAOs, in addition to those set forth in the overview section, is set forth below.

In Florida, a physician was sentenced to 12 years imprisonment for conspiracy to submit false claims to Medicare and to prepare false health benefit claim forms, conspiracy to violate the Medicare kickback statute, and for conspiracy to distribute prescription narcotics. The physician was also ordered to pay restitution in the amount of $350,000 and was ordered to forfeit an additional $250,000. The physician, who purportedly ran a pain management clinic, in fact ran a prescription drug "pill mill" which provided drug addicts with large quantities of prescription pain killers. The physician submitted claims to the Medicare, Medicaid and private health benefit programs claiming to have provided non-rendered medical treatment to the addicts. In the same case, the physician's in-house pharmacist was convicted of conspiracy to distribute prescription narcotics and was sentenced to 16 years imprisonment.

In Indiana, a podiatrist was sentenced to 68 months in prison following his guilty pleas to six counts of mail fraud for fraudulently billing the Medicare, Medicaid and TRICARE programs for a number of complex services that were medically unnecessary. In addition to being sentenced to prison, the podiatrist was ordered to make restitution in the amount of $2.76 million: $2.4 million to the Indiana Medicaid Program; $504,000 to Medicare; and $16,000 to TRICARE.

In Florida, the owner of a medical personnel staffing and home health management company was sentenced to 37 months in prison and ordered to pay $923,100 restitution for defrauding TRICARE and Medicare. The investigation disclosed that between 1992 and 1996, the company fraudulently received reimbursements from TRICARE and Medicare for costs allegedly incurred for overhead expenses and direct patient care which were falsely reported as furniture costs, salary costs, Christmas bonuses, and "royalty fees." The company owner, with the assistance of his son, also paid kickbacks to three doctors for referrals to the home health company.

In Virginia, the president of a medical transport company was sentenced to 37 months after pleading guilty to one count of health care fraud for fraudulently billing the Medicaid Program for approximately $1.4 million. In addition to the prison term, the president was required to pay $1.4 million in restitution, and to forfeit an additional $375,000. The scheme involved the submission of thousands of claims fraudulently seeking payment for the transportation of ambulatory patients who were falsely billed to Medicaid as being wheelchair-bound patients, and the submission of billings for services not rendered and for transportation to destinations not covered by Medicaid.

In New York, a physician pleaded guilty to one count of health care fraud for fraudulently billing Medicare and private health insurance companies for over $10 million billed in a scheme through which the physician billed for "nerve block" injections when in fact he only performed considerably less expensive acupuncture treatments. As a result of the false billings, the physician received $800,000 from Medicare and an additional $600,000 from ten private insurance companies. Pursuant to the plea agreement, the physician has agreed to forfeit $820,000 to the government, repay the private insurance companies $529,000 in restitution, and pay $500,000 to settle a related civil FCA case.

Accomplishments - Civil Cases

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

Each time a civil referral is made to a USAO it is opened as a matter pending in the district. Civil health care fraud matters are referred directly from Federal or state investigative agencies, or result from filings by private persons known as "relators," who file suits on behalf of the Federal Government under the 1986 qui tam amendments to the FCA. Relators may be entitled to share in the recoveries resulting from these lawsuits. At the end of 2001, the USAOs had 1,746 civil health care fraud matters pending. A matter becomes a case when the United States files a civil complaint, or intervenes in a qui tam action, in United States District Court. The vast majority of civil health care fraud cases and matters are settled without a complaint ever being filed. In

2001, 188 civil health care fraud cases were filed. A sample of the civil cases brought by USAOs, in addition to those in described in the overview section, are set forth below.

Seven hospitals located throughout the country agreed to pay the United States almost $5.5 million to settle claims that they unlawfully charged the Medicare and TRICARE programs for surgical procedures using experimental cardiac devices. The devices had not been approved for marketing by the FDA at the time the procedures were performed between 1987 and 1994. The settlement involved hospitals in Florida, California and Arizona. The government had previously entered into settlements with other hospitals engaged in similar conduct and these other settlements resulted in payments of almost $13 million. The settlement stems from a qui tam filed by a former medical device salesman.

In Maryland, a nursing home agreed to forego approximately $436,000 in Medicare and Medicaid reimbursements to resolve allegations that the facility provided substandard nursing home care between November 1998 and December 1999. In addition to the monetary settlement, the nursing home entered into a comprehensive CIA with the government.

A managed care organization in Illinois agreed to pay $2.9 million to settle civil allegations that it defrauded Medicare by obtaining excessive capitated payments for beneficiaries who were institutionalized. Based upon an audit by HHS/OIG, it was determined that the managed care organization incorrectly categorized some of its beneficiaries living in several counties in Illinois as being institutionalized between October 1, 1995 and September 30, 1997. As a result, the managed care organization received enhanced capitated payments from Medicare to which it was not entitled. A 1998 HHS/OIG audit of a sample of the managed care organization's claims for institutionalized beneficiaries revealed that 29 percent were incorrectly categorized as institutionalized. In addition to the settlement, the managed care organization also entered into a CIA with the HHS/OIG.

In California, two medical practice groups agreed to pay $10.25 million to settle allegations that they knowingly defrauded Medicare, TRICARE and Medi-Cal from 1992 to 1999 by submitting numerous false claims to inflate reimbursement payments from Medicare, TRICARE and Medi-Cal. The false billings alleged included: (1) billing for nonreimbursable annual physical exams; (2) billing for routine doctor "referrals" as more highly reimbursable "consultations;" (3) exaggerating the complexity of "evaluation and management" office visits to obtain greater reimbursement; and (4) billing for undocumented lab work and other ancillary services.

Civil Division

Civil Division attorneys vigorously pursue civil remedies in health care fraud matters, working closely with the USAOs, the FBI, the Inspectors General of the Department of Health and Human Services 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, the TRICARE program of the Department of Defense, the FEHBP, and other government health care programs.

Accomplishments

In 2001, the Division opened or filed a total of 92 health care fraud cases or matters. In addition to these new efforts, the Civil Division pursued over 425 existing cases. A significant number of these health care fraud cases have the potential for particularly high damages. Civil Division attorneys were actively involved in the recoveries described in the overview - HCA, Vencor, Quorum, LifeScan, NHC, and Bayer. The following examples demonstrate the breadth and significance of other cases in which the Division was involved during 2001.

The University of California agreed to pay the Government $22.5 million to settle allegations that the school's five teaching hospitals routinely submitted false billings to Medicare, Medicaid and other Federally-funded health programs. The alleged false claims included upcoding, as well as billing for services purportedly performed or supervised by faculty physicians - when those services were, in fact, performed by residents with little or no supervision.

In another recovery in the ongoing "Operation LABSCAM" investigation, Quest Diagnostics agreed to pay more than $13 million on behalf of Nichols Institute. Beginning in 1989 and ending shortly after its acquisition by Quest in 1994, Nichols routinely billed Federal health programs for laboratory test that were medically unnecessary. Collectively, the Government has recovered over $850 million from the nation's clinical laboratories as a result of LABSCAM and related investigations.

The civil complaints in four qui tam suits against a lab which specializes in bladder and prostate cancer testing were settled by a $9.1 million payment to the Government. The allegations against Urocor included upcoding, unnecessary testing, and paying kickbacks to referring physicians. Urocor will enter into a five-year CIA.

Following a bench trial, the Government was awarded treble damages and penalties totaling $7.7 million for Medicare fraud committed by Century Health Services, a chain of ten home health care agencies. Medicare permits reimbursement for staff benefits, including corporate contributions to employee stock ownership plans. However, the defendants used the stock plan reimbursements for their personal benefit, leaving the plan barren. The award is under appeal.

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

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

Vital resources were made available from the Account to provide the Civil Division with Automated Litigation Support, auditors, and consultants. These resources supplemented other Civil Division funds. During 2001, the majority of these monies were used to support two cases - HCA (Columbia) and the Department's tobacco litigation.

Criminal Division

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

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

- providing frequent advice and written materials on confidentiality and disclosure issues arising in the course of investigations and legal proceedings regarding medical records.

- monitoring and coordinating Departmental responses to major regulatory initiatives, legislative proposals, and enforcement policy matters. Examples include issues such as provider education and regulation, medical records privacy, Internet sales of drugs and medical products and expansion of the Medicare program to provide prescription drug benefits.

- reviewing and commenting on numerous requests for advisory opinions submitted by health care providers to the HHS/OIG and consulting with the HHS/OIG on draft advisory opinions per the requirements of HIPAA.

- working with CMS officials to promote more effective use of technologies and high-tech approaches for combating health care fraud and abuse. DOJ and CMS prepared a report with recommendations for future follow-up action based on a national conference held for representatives from Federal, state and local health care programs and law enforcement agencies to exchange information on electronic tools, analytical techniques, and collaborative approaches for detecting and preventing health care fraud and abuse.

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

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

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

The Fraud Section has responsibility for handling complex health care fraud litigation nationwide and examples of successful prosecutions in FY 2001 include:

- HCMF Corporation, a privately owned nursing home chain in Virginia, which was entitled under the Medicare and Medicaid programs to claim reimbursement for the administration costs associated with its operation of eighteen nursing homes throughout Virginia, pleaded guilty to improperly claiming reimbursement for salaries and benefits paid to more than thirty HCMF owners, family members and employees who performed little or no function for the nursing homes or whose duties were largely unrelated to operating the homes. HCMF also submitted false and misleading documentation to Medicare and Medicaid auditors in order to justify these claims. As part of its plea agreement, HCMF agreed to pay restitution to these programs in the amount of $1.7 million, and the Chairman of HCMF's Board of Directors was held jointly and severally liable for the restitution amount. Both the Chairman, and the Treasurer of HCMF pleaded guilty to making false statements in connection with a Federal health care program, and for concealing information from Medicare and Medicaid so that HCMF could continue receiving reimbursement. In addition to any criminal sentences imposed, these two officers, by virtue of their guilty pleas, will be excluded from the health care benefit programs for at least five years.

Civil Rights Division

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

The Section plays a critical role in the HCFAC Program. As the sole component responsible for the Civil Rights of Institutionalized Persons Act, 42 U.S.C. ï¿½ 1997 (CRIPA) authorizes investigation of conditions of confinement at state and local residential institutions (including facilities for persons with developmental disabilities or mental illness, and nursing homes) and initiation of civil action for injunctive relief to remedy a pattern or practice of violations of the constitution or Federal statutory rights. The review of conditions in facilities for the mentally ill and for persons with developmental disabilities, and nursing homes comprises a significant portion of the program. The Special Litigation Section works collaboratively with the USAOs around the country and with HHS.

Accomplishments

As part of the Department's Institutional Health Care Abuse and Neglect Initiative, and as an enhancement to the Department's ongoing CRIPA enforcement efforts, the Special Litigation Section staff began preliminary inquiries into conditions and services at 29 nursing home facilities in 15 states. Our task in preliminary inquiries is to determine whether there is sufficient information supporting allegations of unlawful conditions to warrant formal investigation under CRIPA. Conditions uncovered at one nursing home will be the subject of a full CRIPA investigation. Inquiries regarding the remaining 28 facilities are continuing. In addition, Section staff are conducting preliminary inquiries of two public facilities for persons with mental illnesses.

The Special Litigation Section staff participated in ongoing nursing home investigations, including the investigation of Laguna Honda Hospital in San Francisco, California, one of the largest public nursing home facilities in the United States. This work involved on site evaluation tours with expert consultants, review of documentary evidence and interviews of staff. Further tours of Laguna Honda are scheduled for the next fiscal year. Staff attorneys also presented oral argument as amicus curiae in a private lawsuit brought concerning Laguna Honda, Davis v. California Health and Human Services Agency (N.D. Cal.), regarding the proper interpretation of the integration regulations under the Americans with Disabilities Act (ADA), 42 U.S.C. ï¿½ 12131. Subsequently, the court ruled that the integration mandates of Title II of the ADA might oblige defendants

to expand community services for Laguna Honda residents and to place them in the community as appropriate to their needs.

In addition, the staff conducted four CRIPA investigations of residential facilities for persons with developmental disabilities: Oakwood Developmental Center in Kentucky; Woodward and Glenwood Centers in Iowa; and Holly Center in Maryland. In both the Kentucky and Iowa investigations, Special Litigation Section staff conducted tours of facilities, accompanied by expert consultants, reviewed documents, and interviewed facility staff. The Special Litigation Section staff are preparing detailed letters which will inform the responsible officials not only of the specific findings made during the investigation, but also of the minimum remedies required to address identified deficiencies. In the Holly Center investigation, negotiations toward settlement are continuing regarding the correction of some remaining deficient conditions. In all of these matters, section staff review situations which may entail alleged abuse and neglect.

The Section staff also conducted compliance reviews in four cases: United States v. Tennessee (M.D. Tenn.) involving Clover Bottom Developmental Center; Harold Jordan Center and Greene Valley Developmental Center; United States v. Tennessee (D. Tenn.) involving the Memphis Mental Health Institute; United States v. New Mexico (D. N. Mex.) regarding the New Mexico School for the Visually Handicapped; and Evans and United States v. Williams (D. D.C.) involving dozens of community placements and services for persons with developmental disabilities in the District of Columbia. In each of these cases, staff reviewed compliance with the terms of previously filed agreements and court orders. In addition to compliance activities in Evans, staff were active in negotiating a new consent order and settlement agreement which established the Quality Trust for Individuals with Disabilities, a nonprofit organization independent of the parties that will provide advocacy and legal services to consumers within the District of Columbia's developmental disabilities system. The District agreed to pay an initial sum of $11 million into a trust, and to fund the Quality Trust at a rate of $2 million per year for the first 10 years to allow the trust to grow. The result will be a permanent, independent advocacy organization.

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

Justice Management Division

The Justice Management Division, Debt Collection Management Staff continues to perform for the program various administrative and coordination duties. The duties of this office include: budget formulation, oversight and coordinating with the Office of Management and Budget and CMS; coordinating with HHS/OIG and the Department of the Treasury on the tracking of collections; coordinating with the GAO on required audits; and preparation and coordination of the annual report. In addition, $629,000 for the Nursing Home Initiative was administered by this office.

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 2001, $88,000,000."*

The health care industry is an attractive target to fraudulent activity which, if not aggressively pursued, can have a significant detrimental effect on the financial stability of the U.S. health care system. As such, successful health care fraud enforcement cannot be achieved by one agency alone. Investigations must be a cooperative

effort if they are to be successful in combating the increasing problems of health care fraud. The FBI is actively involved in this cooperative effort.

The FBI works many health care fraud cases on a joint basis with other Federal agencies, including the HHS/OIG. These two Federal agencies collaborate through attendance at health care fraud working groups, attend each others training conferences, and have a liaison program between the two organizations. In addition, most health care fraud task forces formed by FBI field divisions represent the coordinated efforts between the FBI, state and local law enforcement, Federal investigative agencies such as HHS/OIG, and private industry. The FBI and HHS/OIG continue to share a common commitment to ending fragmented health care fraud enforcement efforts and encouraging the coordination of investigative resources.

Under HIPAA, the FBI was provided $88 million in 2001 for health care fraud enforcement. This money was used to support 776 positions (445 agents) funded in prior years and an additional 48 positions (30 agent) in 2001. Currently, the FBI has 14 dedicated health care fraud squads across the country. As the FBI has increased the number of agents assigned to health care fraud investigations, the number of pending investigations has increased over 400 percent rising from 591 cases in 1992 to 2,870 cases through 2001. The FBI is the only Federal investigative agency to have jurisdiction over both government sponsored health care programs and privately funded health care programs. Criminal health care fraud convictions resulting from FBI investigations has risen from 116 in 1992, to 650 through 2001.

Health care fraud investigations are among the highest priority investigations within the FBI. The investigations are generally complex and require specific knowledge, skills and abilities to successfully investigate. Often, sophisticated, innovative, and creative ideas are needed to combat and eventually prosecute the perpetrators of these crimes. As the complexity and long-term nature of health care fraud investigations increase, the FBI anticipates that the number of FBI investigations and convictions will begin to level off.

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

The funding made available through HIPAA also made possible a health care fraud Managers Conference and several Regional Training Conferences for FBI Agents and Professional Support assigned to health care investigations. These training sessions provided in-depth training on the Medicare program and current health care fraud trends and issues to approximately 300 investigative personnel. Other training made possible by HIPAA included: training sessions on data mining and Medicaid fraud. Further, HIPAA funding was utilized to fund training sponsored by various private organizations.

GLOSSARY

The Account - The Health Care Fraud and Abuse Control Account

ACE - Affirmative Civil Enforcement

ADA - Americans with Disabilities Act

AoA - Administration on Aging

ASBTF - Assistant Secretary for Budget, Technology and Finance

CIA - Corporate Integrity Agreement

CMS - Centers for Medicare and Medicaid Services

CRIPA - Civil Rights of Institutionalized Persons Act

DME - Durable Medical Equipment

DOJ - The Department of Justice

FBI - Federal Bureau of Investigation

FCA - False Claims Act

FDA - Food and Drug Administration

FEHBP - Federal Employees Health Benefits Program

GAO - General Accounting Office

HHS - The Department of Health and Human Services

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

IHS - Indian Health Service

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

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

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

PAM - payment accuracy measurements

The Program - The Health Care Fraud and Abuse Control Program

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

SMP - Senior Medicare Patrol

TAG - Technical Advisory Group

USAO - United States Attorney's Office

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1. Hereafter, referred to as the Secretary.

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

3. In 2001, DOJ collected, or continued to hold in suspension, additional funds from health care fraud cases and matters that were not disbursed to the affected agencies and/or the Account in 2001 due to: (i) ongoing litigation regarding relator shares in *qui tam* cases that will affect the amount retained by the Federal government; and (ii) receipt of funds late in the year that were then processed in FY 2002.

4. In addition, HHS/OIG obligated $1,622,000 in funds received as "reimbursement for the costs of conducting investigations and audits and for monitoring compliance plans" as authorized by section 1128C(b) of the Social Security Act, 42 U.S.C. 1320a-7c(b).