

**The Department of Health and Human Services
And
The Department of Justice
Health Care Fraud and Abuse Control Program
Annual Report For FY 1998**

February 1999

TABLE OF CONTENTS

- [Executive Summary](#)
- [Introduction](#)
- [Monetary Results](#)
- [Expenditures](#)
- [Department of Health and Human Services](#)
 - [Office of Inspector General](#)
 - [Health Care Financing Administration](#)
 - [Health Resources and Services Administration](#)
 - [Office of the General Counsel](#)
 - [Administration on Aging](#)
- [Department of Justice](#)
 - [United States Attorneys](#)
 - [Civil Division](#)
 - [Criminal Division](#)
 - [Justice Management Division](#)
- [Appendix: Federal Bureau of Investigation - Mandatory Funding](#)
- [Glossary of Terms](#)

GENERAL NOTE: All years are fiscal unless otherwise noted in the text.

EXECUTIVE SUMMARY

The detection and eradication 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 (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. HIPAA made available much needed and powerful new criminal and civil enforcement tools and financial resources that permitted the government to expand and intensify the fight against health care fraud.

The second year of operation under the Health Care Fraud and Abuse Control Program saw continuing returns to the Medicare Trust Fund, a rise in the number of individuals excluded from participation in federally-funded health care programs, and the initiation and enhancement of important efforts to *prevent* health care fraud and to safeguard the quality of care furnished to beneficiaries under those programs.

Civil and Criminal Enforcement Actions

Federal prosecutors filed 322 criminal cases in health care fraud cases in 1998 -- a

14 percent increase over the previous year, and 326 defendants were convicted of health care fraud-related crimes. Also in 1998, 107 civil cases were filed, and at the end of the year 3,471 civil matters were pending.

Monetary Results

In 1998, the Federal Government won or negotiated more than \$480 million in judgments, settlements, and administrative impositions in health care fraud cases and proceedings. As a result of these activities, as well as prior-

year judgments, settlements, and administrative impositions, the Federal Government in 1998 collected \$296 million. It should be noted that some of the judgments, settlements, and administrative impositions in 1998 will result in collections in future years, just as some of the collections in 1998 are attributable to actions from prior years.

More than 92 percent (\$271 million) of the funds collected and disbursed in 1998 were returned to the Medicare Trust Fund. An additional \$9 million was recovered as the federal share of Medicaid restitution.

Exclusion from Federally Sponsored Programs

HIPAA expanded and strengthened the government's ability to prohibit companies or individuals who have been convicted of certain health care offenses, lost their licenses, or engaged in other professional misconduct from participating in Medicare, Medicaid or other federally sponsored health care programs. In 1998, HHS excluded 3,021 individuals and entities, an increase of 11 percent over 1997.

Administrative Penalties for "Patient Dumping"

The government expanded its efforts under the Patient Anti-Dumping Statute, which requires hospitals' emergency departments to provide emergency medical screening and stabilizing treatment to individuals needing emergency care. Settlement agreements were entered into with 53 hospitals and physicians -- up from a previous high of 18 settlements in 1996 -- and a record \$1.8 million in civil monetary penalties was collected.

Preventing Health Care Fraud

Preventing health care fraud and abuse is a central component of the Program. The Program's prevention efforts include the promulgation of formal advisory opinions to industry on proposed business practices, industry-specific program compliance guidance, special fraud alerts, corporate integrity agreements with providers who settle allegations of fraud, beneficiary and provider education and outreach, and substantial implemented program improvements.

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 1998

**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 (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 equal to collections 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⁽²⁾ Trust Fund. All funds deposited in the Trust Fund as a result of the Act are available for the operations of the Trust Fund.

The Act appropriates monies from the Medicare Trust Fund to an expenditure account, called the Health Care Fraud and Abuse Control Account (Account), in amounts that the Attorney General and the Secretary jointly certify are necessary to finance anti-fraud activities. The maximum amounts available for expenditure are specified in the Act. Certain of these sums are to be available only for activities of the HHS/OIG, with respect to Medicare and Medicaid programs. In 1998, the second year of the Program, the Attorney General and the Secretary certified

\$119.6 million for appropriation to the Account. A detailed breakdown of the allocation of these funds is set forth later in this report. These resources supplement the direct appropriations of HHS and DOJ that are devoted to health care fraud enforcement. (Separately, the Federal Bureau of Investigation (FBI) received \$56 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:

(A) the amounts appropriated to the HI Trust Fund for the previous fiscal year under various categories and the source of such amounts; and

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

This annual report is submitted in fulfillment of 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 1998, as a result of the combined anti-fraud actions of the federal and state governments and others, the Federal Government collected \$296 million in connection with health care fraud cases and matters⁽³⁾. These funds were deposited with the Department of the Treasury and 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 Transfer/Deposits by Recipient 1998	
Department of the Treasury	
HIPAA Deposits to the Medicare Trust Fund	
Gifts and Bequests	\$ 3,000
Amount Equal to Criminal Fines	2,503,298
Civil Monetary Penalties	1,855,277
Amount Equal to Asset Forfeiture *	0
Amount Equal to Penalties and Multiple Damages	103,025,990
Health Care Financing Administration	27,998,956
OIG Audit Disallowances - Recovered	<u>144,741,634</u>
Restitution/Compensatory Damages	280,128,155
Restitution/Compensatory Damages to Other Federal Agencies	7,488,888
Department of Defense	173,866
Office of Personnel Management	3,125,418

Other	<u>1,270,196</u>
Department of Health and Human Services - Other than HCFA	12,058,368
Relators' Payments **	4,344,610
TOTAL ***	\$296,531,133

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

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

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

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

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

EXPENDITURES

In the second year of operation, the Attorney General and the Secretary certified \$119.6 million as necessary for the Program. The following chart gives the allocation by recipient:

1998 ALLOCATION OF HCFAC APPROPRIATION	
(Dollars in thousands)	
Organization	Allocation
Department of Health and Human Services	\$85,680
Office of Inspector General	2,200
Office of the General Counsel	1,300
Administration on Aging	1,000

Health Resources Services Administration	<u>950</u>
Health Care Financing Administration	91,130
Total	
Department of Justice	
United States Attorneys	23,856
Civil Division	3,803
Criminal Division	561
Justice Management Division	<u>250</u>
Total	28,470
Total	\$119,600

These resources supplement the direct appropriations of HHS and DOJ that are devoted, in part, to health care fraud enforcement. Separately, the FBI received an additional \$56 million in funding which is discussed in the Appendix to this Report.

Overview of Accomplishments

Collections

During this year, the Federal Government won or negotiated more than \$480 million in judgments, settlements, and administrative impositions in health care fraud cases and proceedings. As a result of these activities, as well as prior year judgments, settlements, and administrative impositions, the Federal Government in 1998 collected \$296 million in cases resulting from health care fraud and abuse, of which \$271 million was returned to the Medicare Trust Fund, and \$9 million was recovered as the federal share of Medicaid restitution. It should be emphasized that some of the judgments, settlements, and administrative impositions in 1998 will result in collections in future years, just as some of the collections in 1998 are attributable to actions from prior years.

Judgments/Settlements

Working together, we have brought to successful conclusion the investigation and prosecution of numerous costly health care fraud schemes. These investigations were not limited to providers and suppliers of health care services -- 1998 saw the conclusion of two major investigations involving allegations of fraud on the part of the contractors who process claims on behalf of the Medicare program:

- Health Care Services Corporation, the Medicare carrier for Illinois and Michigan agreed to pay the government \$140 million in settlement of a *qui tam* suit alleging that it shredded claims, altered documents and otherwise manipulated data relied on by HCFA to evaluate its contract performance. In addition to the civil settlement, the corporation agreed to plead guilty to obstructing a federal audit, conspiracy to obstruct a federal audit, and making false statements to HCFA which will result in a \$4 million criminal fine. In order to guard against future misconduct, and to ensure that any potential lapses are detected early, the government and the corporation also entered into a strict corporate integrity agreement. We anticipate collecting these funds in the next fiscal year.
- PBSXACT, the Medicare carrier for several mid-Atlantic states, resolved a 2-year investigation by agreeing to pay \$38.5 million in settlement of allegations that it improperly processed Medicare secondary payor claims, neglected to recover overpayments, bypassed certain computer payment safeguards, and failed to implement required screens for certain lab tests, all of which resulted in false claims to the Medicare program. Again, the contractor agreed to undertake corporate integrity obligations, including training and external reviews of its performance.

HHS and DOJ continue to pursue a number of National and Multi-District Projects including:

- Physicians at Teaching Hospitals: In the sixth resolution of a case in the Physicians at Teaching Hospitals or "PATH" project, the government reached settlement with a state university school of medicine for allegedly

billing the Medicare and Medicaid programs in violation of rules governing payment for physician services rendered by residents and interns. The University of Pittsburgh agreed to pay \$17 million to settle potential liability under the False Claims Act and Civil Monetary Penalties Laws. The government took steps to prevent future improper claims by negotiating a corporate integrity agreement that, in part, requires periodic audits and reports by the university for a period of five years.

- Diagnosis Related Groups (DRG) 72 Hour Window Project: A joint nationwide project targeting improper Medicare claims by hospitals for outpatient services continued in 1998. Medicare reimbursement of hospitals for inpatient services includes compensation for related outpatient services, such as laboratory tests, provided during the three days preceding the day of admission and during the hospital stay. In addition to recouping charges for amounts improperly paid to hospitals, the settlements under this project require hospitals to establish internal controls to prevent submission of such improper Medicare claims. As of September 30, 1998, 2,483 hospitals had settled with the United States, agreeing to pay a total of \$63,849,947. The project is expected to continue into 1999.

Quality of Care

The destructive impact of fraudulent billing is not measured in dollars only. During 1998, the Program also stepped up pursuit of investigations and prosecutions that directly affect the *quality* of care provided to Medicare, Medicaid and other beneficiaries of government funded health care programs. During 1998, the government utilized the False Claims Act to proceed against nursing homes that furnished substandard, even dangerous, patient care. For example, Chester Care, a chain of three nursing homes in suburban Philadelphia settled an action alleging grossly deficient patient care, in one case resulting in the scalding death of a patient, in which the homes were required to institute rigorous and extensive quality of care compliance provisions. These standards included strict guidelines for the care of nursing home residents with diabetes; standards that in many respects exceed professional standards in the industry. Enforcement of the standards is ensured by an independent monitor; for the worst of the three homes, an outside manager was instituted to oversee all aspects of the facility until such time as HCFA finds that the home has returned to compliance.

The government also concluded its investigation of a publicly owned nursing home for allegations of substandard care (including excessive use of restraints, lack of cleanliness, and a high level of injuries among patients). Again, in settlement of the action, the facility agreed to implement specific protocols to ensure quality of care, and to employ a monitor to ensure full implementation and further safeguard the patients. The impetus for these and similar actions is not only to obtain compensation for the government's losses, but also to prevent future violations and protect patient safety.

Prevention

The Program also continues to focus on *prevention* of health care fraud and abuse through inclusion of rigorous corporate integrity provisions in settlements with alleged offenders, industry-specific program compliance guidance, formal advisory opinions, special fraud alerts, beneficiary outreach, and exclusions from program participation.

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. The continuing accomplishments of the HHS and DOJ and our partners in the coordinated anti-fraud effort, as well as prevention efforts, demonstrate that the increased funds to battle health care fraud and abuse continue to be sound investments.

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 the HHS/OIG. During the second year of the Program, the Act provides that between \$80 and \$90 million be devoted to these purposes. The Attorney General and the Secretary jointly allotted \$85.7 million to the HHS/OIG in 1998, an increase of \$15.7 million over 1997.

With these increased resources, HHS/OIG conducted or participated in 1,114 successful prosecutions or settlements in 1998. For the second straight year, there was a significant rise in the number of individuals and entities excluded from doing business with Medicare, Medicaid and other federal and state health care programs. A total of 3,021 individuals

and entities were so excluded, many as a result of criminal convictions for program-related crimes (584) and criminal convictions for patient abuse or neglect (302). Others were excluded based on licensure revocations (1,251) or other professional misconduct. Overall, there was an 11 percent increase in exclusions (from the 2,700 exclusions in 1997).

In addition to the OIG's role in bringing about the judgments and settlements described in the Overview of Accomplishments, HHS acted on OIG recommendations and disallowed \$27.7 million in improperly paid health care funds in 1998. HHS/OIG continues to work with HCFA 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 1998, such funds not expended on improper or unnecessary care amounted to approximately \$10.8 billion -- nearly \$8.3 billion in Medicare savings, and nearly \$2.6 billion in savings to the Medicaid program.

HHS/OIG moved closer to its goal of extending its investigative and audit staffs to cover *all* geographical areas in the country, particularly those that were under served during lean budget years. During 1998, overall HHS/OIG staff levels increased from 1,126 to 1,258, and HHS/OIG opened five new investigative offices. The staff increases also strengthened the office's ability to conduct rapid national evaluations that provide policymakers with factual information, analysis and recommendations for improving HHS programs. The outcomes of these inspections lead to increased cost savings, improved quality of care or services, improved program efficiency and the identification of program vulnerabilities.

Focus on Prevention

Affirmative enforcement, with an eye toward prosecution or recovery of misspent funds, has been and remains a key role of the HHS/OIG. However, with the increased resources made available under HIPAA, the HHS/OIG has also continued to expand activities designed not just to uncover existing fraud and abuse, but to *prevent* it.

A cornerstone of HHS/OIG's prevention efforts has been the development of compliance program guidance to encourage and assist the private health care industry to fight fraud and abuse. The guidance, developed in consultation with DOJ and the provider community, identifies steps that health providers may voluntarily take to improve adherence to Medicare and Medicaid rules. Each guidance sets forth seven elements that the HHS/OIG considers necessary for a comprehensive compliance program and identifies risk areas for the specific industry sector. In 1998, the OIG issued compliance program guidance for use by hospitals and home health agencies, and issued a revised guidance for clinical laboratories. The HHS/OIG also solicited input from the durable medical equipment industry on issues that should be addressed in upcoming guidance for that health care sector.

With increasing frequency, health care providers that enter agreements with the government in settlement of potential liability for violations of the False Claims Act also agree to adhere to a separate "corporate integrity agreement." Under this agreement, the provider commits to establishing a compliance program or undertaking other specified steps to ensure their future compliance with Medicare and Medicaid rules. The duration of most corporate integrity agreements is 3 to 5 years, during which time the provider must submit an annual report to HHS/OIG on its compliance activities. At the close of 1998, the OIG was monitoring approximately 350 agreements; a total of 231 corporate integrity agreements were entered into in 1998.

Industry outreach and education is another critical component of fraud prevention. During this past year, the HHS/OIG issued final regulations, in consultation with DOJ, implementing a process for issuing written advisory opinions to the public on the sanction authorities enforced by HHS/OIG, including the anti-kickback statute and the Civil Monetary Penalties Law. In 1998, HHS/OIG issued 15 advisory opinions on a wide range of concerns. Moreover, HHS/OIG received 21 requests for opinions in the last quarter of the year, almost 40 percent of the total requests for the year, reflecting growing industry recognition of the value of the advisory opinion process. In addition, HHS/OIG issued a special fraud alert on financial relationships between hospices and nursing homes, as well as presented frequent speeches to industry groups on areas of suspected fraud and abuse and measures they can take to avoid trouble.

Enlisting beneficiaries as partners in fighting fraud assists in identifying abuses at an early stage, and preventing ongoing or widespread abuse. An HHS/OIG survey found that Medicare beneficiaries are well-positioned to identify fraud, with three out of four stating that they "always" read their Explanation of Medicare Benefit statements. The HHS/OIG continues to work with the Administration on Aging, HCFA, and the American Association of Retired Persons to develop an outreach campaign to educate beneficiaries and those who work with the elderly to recognize fraud and abuse and to report it appropriately. This campaign will be fully "launched" in 1999. The beneficiary outreach program, in part, encourages individuals to contact the HHS/OIG Hotline, 1-800-HHS-TIPS, which receives complaints of improprieties in Medicare and other HHS programs. In 1998, the Hotline received over 76,000 calls (up from 58,000 in 1997), which resulted in more than 12,500 complaints. Approximately \$1.04 million in collections are associated with complaints referred to and resolved by HCFA and its contractors.

There is a final, and critically important HHS/OIG effort to prevent fraud and abuse. Frequently, investigations (and resulting civil settlements or criminal prosecutions), audits and evaluations reveal vulnerabilities or incentives for fraud in agency programs or administrative processes. As required by the Inspector General Act, the HHS/OIG makes

recommendations to correct 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 fashion legislative proposals and other corrective action that, when enacted or implemented, close loopholes and avoid ineffective expenditures or improper conduct. The savings from these joint efforts toward program improvements can be vast. Among the OIG studies that provided evidence and ideas supporting proposals for significant cost savings during 1998, and studies conducted in 1998 that will likely reap such savings in the future are:

- Home Health - A combination of OIG investigations, audits, and evaluations helped support a general reform of home health services provided by Medicare. Legislation was recently enacted to strengthen and protect the Medicare home health benefit, by establishing payment on a prospective basis for each episode of care, rather than on a visit-by-visit basis. An interim payment system will control reimbursements until the prospective payment system is implemented. The legislation also requires agencies to purchase surety bonds, eliminates periodic interim payments, requires home health agency owners to submit their social security numbers and detailed information about related businesses, authorizes HCFA to re-enroll agencies every 3 years, and gives HCFA more power to refuse to enter into agreements with suspect individuals or companies.
- Nursing Homes - Similarly, new legislation has reformed the way Medicare pays for nursing home services. Again, the new policy adopts a prospective payment system for nursing home stays covered under Medicare Part A. Under new "consolidated billing," nursing facilities must also submit bills for Part B-covered services to Medicare for residents who are either Medicaid or private pay.
- Prescription Drugs - In response to HHS/OIG findings and recommendations that showed Medicare paid more for prescription drugs than the Medicaid program and that Medicare payments greatly exceeded suppliers' acquisition costs, Congress reduced Medicare payment rates for drugs by 5 percent. The new legislation also authorized HCFA to make inherent reasonableness adjustments of up to 15 percent to all Part B services except physician services.
- Hospice Care - A combination of audit and evaluation reports were the subject of numerous congressional hearings and media coverage that resulted in heightened awareness of problems with hospice care especially when provided in nursing homes. New legislation provides more frequent certification of eligibility for the hospice benefit. This will help control costs while improving the overall quality of care for Medicare patients facing death. In addition, the OIG issued a Fraud Alert to the public regarding problems of coordination of hospice benefits with nursing home patients.

In addition to this work already completed, the OIG continues to develop new proposals and new ideas to ensure the integrity of the Medicare program.

Focus on Quality of Care

Some of the HHS/OIG's most important investigations, audits and evaluations focused on the *quality* of care furnished to program beneficiaries. A number of these investigations are described in the "Overview of Accomplishments" section of this report. Others include:

- Investigation revealed that the Northern Louisiana Rehabilitation Hospital was billing Medicare for services that were medically unnecessary or provided no benefit to the Medicare patient. The hospital also delayed discharging Medicare patients in order to bill additional services to Medicare. The hospital and its majority stock holder agreed to pay nearly \$4.5 million in settlement of these allegations of false claims to Medicare.
- In partnership with the Illinois State Medicaid agency, the HHS/OIG investigated Home Pharmacy Service, Inc, a pharmacy that provided services to nursing homes, for failing to return unused medications after the resident died. Instead, the pharmacy allegedly reused the medications, thereby both potentially endangering patients and submitting false claims to Medicaid. The pharmacy settled these allegations for \$5.3 million.
- Corporate integrity agreements can also be an important instrument in safeguarding patient quality of care. For example, Charter Behavioral, a psychiatric hospital, agreed to having a monitor selected by the government to oversee the medical necessity for and duration of each admission, and otherwise review the quality of patient care. As mentioned in the Overview of Accomplishments, a Pennsylvania nursing home also signed a settlement agreement that included strict guidelines for the care of nursing home patients with diabetes.

Both HCFA and the HHS/OIG have significantly stepped up enforcement actions under the patient anti-dumping statute. Federal law requires that an emergency medical screening examination and stabilizing treatment be provided by the emergency department of a Medicare participating hospital. The HHS/OIG is currently investigating over 150 instances, in which individuals were allegedly refused medical screening or treatment that were analyzed and referred by HCFA. In 1998, HHS/OIG entered 53 settlement agreements with hospitals and physicians and collected civil monetary penalties of \$1.8 million. This is a marked increase from the previous high of 18 settlements in 1996, and

reflects the commitment of both HCFA and HHS/OIG to ensure patient access to appropriate emergency medical services.

Elder abuse in nursing homes is of growing concern. An HHS/OIG review concluded that state safeguards do not ensure that potentially dangerous applicants are identified and denied employment in nursing homes. States rely on a patchwork of measures, such as criminal background checks and screens of nurse aide registries. These safeguards vary widely among the states. Moreover, where screens exist, they often apply only to "in-state" records that do not include information on some individuals' criminal histories.

Training

The Office of Investigations (OI) has held numerous conferences and training seminars during the first two years of HIPAA. These include two durable medical equipment conferences; eight HCFA contractor fraud unit training seminars and one conference on fraud in home health agencies. Outreach programs on durable medical equipment and home health agencies were given in coordination with the HCFA contractor fraud units throughout the country to members of the health care community. In addition, OI personnel have made presentations to provider organizations on current issues of health care fraud and abuse. The organizations include hospital, home health, hospice and nursing home associations.

Other Initiatives to Combat Health Care Fraud and Abuse

The annual audit of HCFA's financial statements (mandated by the Chief Financial Officers Act and the Government Management Reform Act) provides an objective evaluation of the reliability of those statements and, importantly, an evaluation of financial management processes, systems and internal controls. The fiscal year 1997 audit, jointly funded by HHS/OIG and HCFA, noted an improvement in federal financial accountability. HHS/OIG issued a qualified opinion; an improvement over the disclaimer issued for the previous year. Because of continuing problems, however, OIG was unable to issue an unqualified (or "clean") opinion. The audit report estimated that improper Medicare fee-for-service payments in 1997 amounted to about

\$20.3 billion, or about 11 percent of the total \$177.4 billion in fee-for-service payments. Much of these improper payments were the result of insufficient or no medical documentation of the services, lack of medical necessity, incorrect coding, and unallowable services. The audit did not determine what portion of these improper payments are attributable to fraud. Additionally, OIG identified systemic internal control problems. HCFA continues to work with the HHS/OIG in its efforts to complete corrective action.

With more than six million Medicare beneficiaries receiving health care services through managed care plans (as of February 1998), the HHS/OIG conducted various reviews assessing this health care delivery option. Among these, the HHS/OIG evaluated beneficiary and provider satisfaction with HMOs and other managed care plans, reviewed the components of the administrative costs included in calculating the adjusted community rate and recommended that legislation be sought that would exclude inappropriate expenses that currently inflate that rate beyond what is Medicare's "fair share" (with a potential cost saving of \$1 billion); and made recommendations to improve beneficiaries' access to services.

Health Care Financing Administration

The Health Care Financing Administration (HCFA) is the agency with primary responsibility for administering the Medicare and Medicaid programs. HCFA has a mandatory appropriation to support its Medicare Integrity Program⁽⁴⁾, however, appropriations for the integrity program cannot be used in support of activities conducted directly by agency personnel.

In 1998 HCFA received \$950,000 from the Account to support efforts at controlling fraud and abuse in the Medicare program.

- **Medicare Satellite Offices.** \$720,000 in HCFAC funds were used to continue Satellite Office operations in Miami and to open a new satellite office in New Orleans, Louisiana.

Satellite Offices' support newly established, cross-jurisdictional partnerships with various entities that had previously worked in isolation to combat fraud. Specifically, Satellite Office staff are charged with working directly with staff of other federal agencies, various law enforcement agencies, relevant state agencies and various private companies to function as a "hub" coordinating and helping avoid duplication in the fraud prevention, detection and elimination efforts of these partners.

The New Orleans Office opened mid-year and spent a considerable portion of 1998 getting established; the Miami office continued to enjoy the success needed to demonstrate the viability of the Satellite Office. Since 1996, the Miami office, working collaboration with its partners in Florida, has identified significant fraudulent and abusive claims against the Medicare and Medicaid programs, resulting in the identification of \$75 million in

overpayments. In addition, the collaborative projects focused on identifying the root causes of fraud, waste and abuse, so that corrective action could be taken and further occurrences prevented.

- **State Survey and Certification projects.** \$230,000 in HCFAC funds were used to support continuation of state survey and certification projects.

State survey agency personnel were trained on methods to identify problem providers and used that training as part of their ongoing survey work in laboratories and other health care facilities. HCFAC funds supported state personnel and HCFA oversight of these activities for projects in 25 states.

Health Resources and Services Administration

The Act mandates that the HHS/OIG and DOJ establish a national health care fraud and abuse data collection program for the reporting and disclosure of certain final adverse actions (excluding settlements in which no findings of liability have been made) taken against health care providers, suppliers, and practitioners. The Health Resources and Services Administration (HRSA) is authorized to design, implement and operate this program, currently named the Healthcare Integrity and Protection Data Bank (HIPDB). In 1998, HRSA was allocated \$1 million from the Account to further development of the HIPDB.

The HIPDB initial operating capability stage was completed and tested in March 1998. The next stage of development included the addition of systems capability to receive adverse licensure and certification reports, as well as reports of other adverse federal and state actions, on health care practitioners. The HIPDB also was developed to receive reports of all types of health care related final adverse actions against health care providers and suppliers. The first generation of the HIPDB will be substantially complete by May 1999. Pursuant to the Act, the HIPDB may not open for operations until final regulations are issued by the Secretary.

The HIPDB system has undergone and successfully completed Y2K compliance testing to ensure that dates beginning with the year 2000 will not disrupt operations. Once the HIPDB becomes operational, the query fee payment will be collected via an interface with Mellon Bank. This link is the only part of this data collection program that has not yet undergone Y2K compliance testing. Certification regarding Y2K compliance is expected from Mellon Bank in 1999.

Progress to date includes:

- design specifications developed and approved;
- specific design reviews conducted of key hardware and software;
- physical facilities modified to accommodate the new equipment; and
- equipment ordered, received, installed and currently in use for the development of the system.

Data acquisition activities including working with:

- DOJ to acquire all federal judgments and convictions;
- HCFA to acquire Medicare and Medicaid adverse and exclusion actions;
- Departments of Defense and Veterans Affairs to acquire disciplinary and adverse actions; and
- Various health care related and health professional organizations, including those representing Nursing and Chiropractic Licensing Boards.

Office of the General Counsel

The Office of the General Counsel (OGC) headquarters' divisions (the Health Care Financing Division and the Business and Administrative Law Division) as well as its 10 regional offices provide legal support under the HCFAC Program.

OGC was allocated \$2.2 million in HCFAC funding for 1998. These funds were used for litigation activity, both administrative and judicial. OGC continues to experience an increase in the number of new litigation items: a 104 percent increase in 1997 and a 17 percent increase in 1998. The bulk of the administrative (non-court) litigation involved: (1) civil money penalties (CMP) imposed on Medicare nursing facilities; (2) revocations, terminations or denials of provider status (especially home health agencies, nursing facilities, and Community Mental Health Centers); (3) Medicare Secondary Payor (MSP) cases; and, (4) Medicare suspensions of payments to providers and suppliers. The bulk of the court litigation involved MSPs or bankruptcies.

Accomplishments

- Prospective Payment System (PPS) Transfer Recovery Project: OGC's HCF Division has been assisting OIG and DOJ in a nationwide False Claims Act initiative. HHS/OIG has been investigating certain PPS hospitals that improperly code patients as being discharged from the hospital when the patients have, in fact, been transferred to another PPS hospital. Medicare regulations allow a hospital to receive the full DRG payment for a patient who is discharged from the hospital. Hospitals that transfer patients to another PPS hospital, however, are entitled to receive only a per diem payment for the actual length of stay at the first hospital. The OIG's investigation has found that thousands of hospitals miscoded transfers of patients as discharges, causing Medicare to pay the full DRG payment improperly to both the transferor and transferee hospitals.
- OGC's Region I office, working with HCFA, defended HCFA against a legal challenge brought by a large national nursing home chain. In a case involving one of the chain's facilities in Region I, OGC's assistance resulted in the termination of the facility's Medicare provider agreement, and the imposition of a CMP in the amount of \$637,000.
- Region III, in collaboration with the U.S. Attorney's Office in Philadelphia, issued the first joint DOJ/HCFA Consent Order against a skilled nursing facility in a fraud case. The facility and two related facilities agreed to pay \$500,000 in CMPs; implement staffing changes pursuant to federal regulations; and, adopt a corporate compliance program.
- The Region V office had a record high 940 new MSP cases filed in 1998. Contributing to this were partnership arrangements with contractors and U.S. Attorneys in Michigan and Ohio as well as a new notice letter to assist fiscal intermediaries in recoveries. This effort contributed to nearly \$3.6 million in Medicare recoveries through MSP litigation.
- OGC's Region VI in cooperation with HCFA, was instrumental in suspending payments to 40 providers and suppliers on the basis of fraud and misrepresentation with only one suspension challenged in court.

Administration on Aging

The Administration on Aging (AoA) is the only federal agency with sole responsibility for program policies and services for older Americans. In 1998, the AoA was allocated \$1.3 million under the Program. These funds continued to train and educate both paid and volunteer staff in the aging network, especially those associated with Older Americans Act programs and services, such as long-term care ombudsmen, to recognize and report potential practices and patterns of fraud and abuse in the Medicare and Medicaid programs. Additionally, AoA and its network agencies engaged in outreach and educational activities to assist older persons, their families and their communities to recognize and report fraudulent and abusive situations and to prevent or minimize victimization by such behavior.

Accomplishments

- Increased to 18 the number of cooperative agreements to state units on aging to support education, training and outreach efforts to help aging network staff and volunteers to recognize and report health care fraud and abuse. Based on a pre-test of AoA's HCFAC/ORT performance measures, the following activities were documented:
 - Cumulatively, more than four and a half million people were reached through public service announcements, community education events, and other activities.
 - 275 formal training sessions were conducted for over 8,500 aging network staff and volunteers who, in turn, conducted public information forums attended by over 15,000 persons. Over 100 brochures, manuals, and videos were developed and publicly distributed to support training efforts.
- Based on information gathered from AoA's partners and stakeholders, the agency developed and implemented a series of new technical assistance activities designed to more effectively carry out their mandates, including:
 - Planning and convening a 3 day national technical assistance and resource exchange conference in August 1998.
 - Establishing a limited access internet "chat room," and creating and maintaining an AoA anti-fraud web page.
 - Establishing a bi-monthly "AoA Fraud Watch" newsletter designed to exchange updates, best practices, resources, and information between AoA's community volunteer and education projects.
- HCFAC funding also provided vital technical assistance support to AoA's twelve Community Volunteer Projects which have been highly successful in recruiting and training retired professionals to identify and report waste, fraud and abuse. In its first year of operation, these Community Volunteer Projects trained more than 3,600 retired older Americans how to review their Explanation of Benefit Statements for potential waste, fraud and abuse. The senior volunteers in turn held over 1,300 group and counseling sessions attended by more than

41,000 Medicare beneficiaries on strategies for combating, preventing, and reporting waste, fraud and abuse in the Medicare and Medicaid programs.

FUNDING FOR DEPARTMENT OF JUSTICE

United States Attorneys

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

USAOs continue to cooperate closely with numerous federal, state and local law enforcement agencies who are involved in the prevention, evaluation, detection, and investigation of health care fraud. In addition to the HHS/OIG and HCFA, these agencies include the State Medicaid Fraud Control Units; Inspectors General Offices of other federal agencies; the Drug Enforcement Administration; Department of Defense, Defense Criminal Investigative Service; and the TRICARE Support Office in the Department of Defense.

To assist in coordination and communication at national, state, and local levels, each USAO has appointed both a criminal and civil health care fraud coordinator. Prior to the enactment of HIPAA, USAOs dedicated substantial resources to combating health care fraud, 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 1998, OLE conducted a number of presentations and complete courses on health care fraud, including:

- Affirmative Enforcement/Health Care Fraud Investigators Session
- Basic Health Care Fraud for Attorneys
- Basic Affirmative Civil Enforcement - includes a health care fraud component
- Advanced Affirmative Civil Enforcement - which includes a health care fraud component
- Advanced Health Care Fraud for Attorneys
- Basics of Medicare for Attorneys and Paralegals

While the primary student body at each of these courses were DOJ employees, personnel from HHS/OIG and other agencies were also invited to participate as presenters and students. Additionally, USAO attorneys, investigators and auditors participated in a number of non-OLE sponsored, multi-agency health care fraud training courses over the last year.

Accomplishments - Criminal Prosecutions

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

Each time a criminal case is referred to a USAO from the FBI, HHS/OIG, or other law enforcement agency, it is opened as a matter pending in the district. A case remains a matter until an indictment or information is filed or the case is declined for prosecution. In 1998, the USAOs had 1,866 criminal matters pending involving 2,986 defendants, a 23 percent increase over 1997. 322 cases were filed with 439 defendants. This represents a 14 percent increase over cases filed in 1997. Health care fraud convictions include both guilty pleas and guilty verdicts. During 1998, there were 219 criminal health care fraud convictions, involving 326 defendants.

In one case, the owner of The Human Resources Inc. Concept, pleaded guilty to charges that he defrauded the Medicaid program of \$7.3 million by billing it for individual and group psychotherapy sessions allegedly provided to children attending after-school and summer day camp programs. After 4 days of trial testimony, the defendant pleaded guilty to one count each of conspiracy and mail fraud. The defendant and others recruited inner-city school children, who were eligible for Medicaid, to enter after-school and summer school programs at a community center and roller

skating rink. These programs were promoted as providing academic and cultural enrichment and recreational opportunities. The defendant directed employees to go door-to-door in poor areas to recruit children without telling the parents that Medicaid would be billed for individual or group psychotherapy sessions. Parents testified that they had not enrolled their children for psychotherapy sessions, and that their children did not need those services. Several former employees testified that psychological counseling was not provided. On September 30, 1998 the defendant was sentenced to 3 years and 10 months in federal prison, and ordered to pay \$7.3 million in restitution.

Accomplishments - Civil Cases

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

Each time a civil matter is referred 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 False Claims Act and may be entitled to share in the recoveries resulting from these lawsuits. At the end of 1998, the USAOs had 3,471 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* complaint, in United States District Court. A large majority of civil health care fraud cases and matters are settled without a complaint ever being filed. In 1998, civil health care fraud cases filed increased 20 percent over 1997, from 89 to 107.

A significant agreement in 1998 arising from a *qui tam* case, involved Health Care Service Corporation (HCSC), the Medicare contractor for Illinois and Michigan, in which the company agreed to plead guilty to eight felony counts and agreed to pay a \$4 million criminal fine and \$140 million in settlement of its liability under the federal False Claims Act. HCSC, also known as Blue Cross and Blue Shield of Illinois, agreed to plead guilty to six counts of making false statements to conceal evidence of its poor performance in processing Medicare claims from HCFA, and two counts of obstructing and conspiring to obstruct federal auditors. The civil settlement resolves allegations that the company falsified documents and manipulated samples used in government audits of the company's Medicare operations, failed to process claims in accordance with guidelines established by HCFA, and failed to handle beneficiary and physician inquiries in a timely manner. Prior to the corporate plea, one former and one current manager at HCSC's Marion office pleaded guilty to charges of conspiracy, wire fraud and obstruction of a federal audit. Through their submission of false information to HCFA concerning the performance of HCSC on its Medicare Part B contracts, HCSC had its contracts with HCFA renewed, and received almost \$1.3 million in incentive payments from HCFA. In December 1997, HCSC agreed to withdraw from the Medicare program and, as of September 1, 1998, was no longer a Medicare contractor. This case combined efforts of the U.S. Attorney in Southern Illinois, the FBI, the HHS/OIG, the U.S. Postal Inspection Service, the Criminal Division, and the Civil Division.

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 HHS and Defense, as well as other federal and state law enforcement agencies. A total of 161 new health care fraud matters were initiated in 1998. In addition to pursuing more health care fraud allegations, the Civil Division is pursuing an increasing number of health care fraud cases in which the apparent single damages are particularly high.

A particularly significant 1998 accomplishment was the \$4.7 million settlement with Charter Behavioral Health Systems, a psychiatric hospital chain, to resolve claims in a *qui tam* lawsuit. The government alleged that a Charter hospital improperly billed Medicare for millions of dollars of psychiatric services rendered to individuals who could not benefit from the services because they had debilitating organic brain disorders, such as Alzheimer's Disease and severe dementia. These beneficiaries were routinely admitted to the hospital by doctors allegedly seeking to increase patient admissions in response to pressure from Charter's corporate headquarters. As part of the agreement, the hospital will be monitored under a 5 year corporate integrity agreement, and will not bill Medicare for any services for a 15- month period.

In another health care *qui tam* case, \$17.2 million was paid by the University of Texas Health Science Center/Medical School at San Antonio to settle allegations that inflated claims for physician services were submitted to Medicare, Medicaid, TRICARE and the State Legalization Alien Impact Assistance Grant program. The government alleged that the Medical Center submitted claims for services personally provided by faculty physicians when, in fact, the Center's records did not support the claim that the faculty member personally provided the service.

In addition, Invacare Corporation paid \$2.6 million to the Department of Veterans Affairs to settle allegations of fraud in the sale of wheelchairs. Invacare allegedly failed to provide accurate and complete cost data during contract negotiations and violated the Buy America Act by supplying foreign-made wheelchairs.

In 1998, the Civil Division received \$3.8 million from the Account. Resources were allocated primarily to fund 33 positions, including attorneys, analysts, auditors, paralegals, secretaries and a litigation support specialist. Because coordination across many organizations and locations is crucial to enforcement efforts, one attorney served as the Civil Division's health care fraud coordinator. This attorney provided guidance and information, developed training, and coordinated policy development and information exchange with other DOJ components, HHS/OIG, HCFA and other Government agencies and the private sector.

Although very limited 1998 resources were available for Automated Litigation Support (ALS), auditors and consultants from the Account, the Civil Division was able to apply other appropriated funds for these critical services. During 1998, much needed ALS was provided to 17 cases while auditor/consultant support was provided to 15 cases. Four of the supported cases have settled, yielding nearly \$14 million. Expected recoveries in the remaining cases range from several million to hundreds of millions of dollars.

Criminal Division

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

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

- updates on criminal, civil, administrative and regulatory efforts to combat health care fraud.
- updates on significant appellate decisions concerning health care fraud prosecutions.
- participation in the negotiated rulemaking committee which sought to develop standards for the shared risk exception to liability under the anti-kickback statute. The committee met several times and developed a committee report which is presently being worked by HHS into its final form.
- development of guidance on suspension of Medicare payments to ensure program integrity. The memorandum provides information to Department attorneys and AUSAs concerning the standards and process for suspension of Medicare payments. It also encourages the attorneys to engage in effective and timely communication with representatives of HCFA to discuss all significant issues which may impact the government's decision whether to employ the suspension remedy in a particular instance.
- development of a Statement of Principles for the Sharing of Health Care Fraud Information Between the DOJ and Private Health Plans. This is a general statement of principles governing the Department's exchange of health care fraud information with private health insurance plans as required by the HCFAC Program Guidelines issued by the Attorney General and the Secretary.
- providing frequent advice and written materials to AUSAs, and investigative agents, on confidentiality and disclosure issues regarding medical records which arise in the course of investigations and legal proceedings.
- 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.

Justice Management Division

The Justice Management Division, Debt Collection Management Staff continues to perform various administrative and coordination duties. The duties of this office include: budget formulation, oversight and coordinating with the Office of Management and Budget and HCFA; development and data collection for the internal program evaluation; coordinating with HHS/OIG and the Department of the Treasury on the tracking of collections; coordinating with the GAO on required audits; and preparation and coordination of the annual report.

APPENDIX

Mandatory Funding

"There are hereby appropriated from the general fund of the United States Treasury and hereby appropriated to the Account for transfer to the Federal Bureau of Investigation to carry out the purposes described in subparagraph (C), to be available without further appropriation-- (I) for fiscal year 1998, \$56,000,000".

Successful health care fraud enforcement cannot be achieved by any one agency alone. Investigations must be a cooperative effort if they are to be successful in combating the increasing problems of health care fraud. The FBI is involved in this cooperative effort. The FBI works many health care fraud cases on a joint basis with other federal agencies, including the HHS/OIG. These two federal agencies collaborate through attendance at health care fraud working groups, attend each others training conferences, and have a liaison program between the two organizations. In addition, the Health Care Fraud task forces represent the coordinated efforts of the FBI, state and local law enforcement, investigative agencies such as Inspectors General, and private industry. The FBI and HHS/OIG share a common commitment to ending fragmented health care fraud enforcement.

In addition to providing new statutory tools to combat health care fraud, HIPAA specified mandatory funding to the FBI for health care fraud enforcement. In 1998, \$56 million was provided by HIPAA for 569 positions (340 agents). The FBI used this funding, in large part, to fund an additional 44 agents and 28 support positions for health care fraud and to create several new dedicated Health Care Fraud Squads. This increase in personnel resources along with the direct FBI funding increased the number of FBI agents addressing health care fraud in the fourth quarter of 1998 to approximately 460 agents as compared to 112 in 1992.

As the FBI has increased the number of agents assigned to health care fraud investigations, the caseload has increased dramatically from 591 cases in 1992, to 2,700 cases through 1998. The FBI caseload is divided between those health plans receiving government funds and those that are privately funded. Criminal health care fraud convictions resulting from FBI investigations have risen from 116 in 1992, to 352 through the third quarter in 1998.

Health care fraud investigations are among those investigations having the highest priority 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, and medical clinics. Further, the Health Care Fraud Unit, FBI Headquarters, supported individual field offices with equipment and supplies to assist in numerous individual investigations.

In January 1998, four former executives of Damon Clinical Laboratory were indicted on federal criminal charges of conspiracy to defraud the Medicare Program of more than \$25 million. These charges are in addition to the Damon Corporate plea in October 1996 when the company pled guilty to conspiracy to defraud Medicare in connection with conduct alleged against these executives, and paid \$119 million to the United States. It is alleged that the individuals conspired to manipulate the way physicians order blood tests.

The funding made available through HIPAA also made possible 4 Regional Training Conferences for FBI agents assigned to health care fraud investigations. These 1 week training sessions sponsored by HCFA provided in depth training on the Medicare Program to almost 250 agents. Other training made possible by HIPAA included: a session for the FBI's Financial Analysts; and a joint FBI, Defense Criminal Investigative Service, HHS/OIG Managers Conference. Further, funding from HIPAA was utilized in Pharmaceutical Division and Cost Report Training sessions to more than 100 FBI agents.

GLOSSARY

Account - The Health Care Fraud and Abuse Control Account

ACE - Affirmative Civil Enforcement

ALS - Automated Litigation Support

AoA - Administration on Aging

AUSA - Assistant United States Attorney

DOJ - The Department of Justice

DRG - Diagnosis Related Group

FBI - Federal Bureau of Investigation

GAO - General Accounting Office

HCFA - Health Care Financing Administration

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

HIPDB - Healthcare Integrity and Protection Data Bank

HRSA - Health Resources and Services Administration

MSP - Medicare Secondary Payer

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

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

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

PPS - Prospective Payment System

Program - The Health Care Fraud and Abuse Control Program

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

USAO - United States Attorney's Office

U.S.C. - United States Code

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 1998, DOJ collected, or continued to hold in suspense, an additional \$96,480,614 in health care fraud cases and matters that was not disbursed to the affected agencies and/or the Account in 1998 due to: (i) on-going 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 1999.

4. The Medicare Integrity Program is run through Medicare contractors and is intended to protect the trust fund from abusive or fraudulent activities.