
**The Department of Health and Human Services
And
The Department of Justice
Health Care Fraud and Abuse Control Program
Annual Report For FY 2006**

November 2007

TABLE OF CONTENTS

	Page
Executive Summary	1
Introduction	3
Monetary Results	5
Program Accomplishments	7
Department of Health and Human Services	
Office of Inspector General	25
Centers for Medicare & Medicaid Services	34
Administration on Aging	34
Office of the General Counsel	35
Health Resources and Services Administration	37
Office of the National Coordinator for Health Information Technology	38
Department of Justice	
United States Attorneys	39
Civil Division	40
Criminal Division	41
Civil Rights Division	43
Appendix: Federal Bureau of Investigation - Mandatory Funding	47
Glossary of Terms	51

GENERAL NOTE

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

EXECUTIVE SUMMARY

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

Monetary Results

During FY 2006, the Federal Government won or negotiated approximately \$2.2 billion in judgments and settlements, and it attained additional administrative impositions in health care fraud cases and proceedings. The Medicare Trust Fund received transfers of approximately \$1.5 billion during this period as a result of these efforts, as well as those of preceding years, in addition to \$177.1 million in Federal Medicaid money similarly transferred separately to the Treasury as a result of these efforts. The HCFAC account has returned over \$10.4 billion to the Medicare Trust Fund since the inception of the program in 1997.

Enforcement Actions

In FY 2006, U.S. Attorneys' Offices opened 836 new criminal health care fraud investigations involving 1,448 potential defendants. Federal prosecutors had 1,677 health care fraud criminal investigations pending, involving 2,713 potential defendants, and filed criminal charges in 355 cases involving 579 defendants. A total of 547 defendants were convicted for health care fraud-related crimes during the year. Also in FY 2006, the Department of Justice (DOJ) opened 915 new civil health care fraud investigations, and had 2,016 civil health care fraud investigations pending at the end of the fiscal year.

¹Hereafter, referred to as the Secretary.

Page intentionally left blank

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 2006**

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

STATUTORY BACKGROUND

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

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

The Act appropriates monies from the Medicare Trust Fund to an expenditure account, called the Health Care Fraud and Abuse Control Account (the Account), in amounts that the Secretary and Attorney General jointly certify as necessary to finance anti-fraud activities. The maximum amounts available for certification are specified in the Act. Certain of these sums are to be used only for activities of the HHS/OIG, with respect to Medicare and Medicaid programs. In FY 2006, the Secretary and the Attorney General certified \$240.558 million for appropriation to the Account. A detailed breakdown of the allocation of these funds is set forth later in this report. These resources generally supplement the direct appropriations of HHS and DOJ that are devoted to health care fraud enforcement. These resources also funded approximately 80% of the HHS/OIG expenses in FY 2006. (Separately, the Federal Bureau of Investigation (FBI) received \$114 million from HIPAA which is discussed in the Appendix.)

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

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

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

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

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

This annual report fulfills the above statutory requirements.

MONETARY RESULTS

As required by the Act, HHS and DOJ must detail in this Annual Report the amounts deposited and appropriated to the Medicare Trust Fund, and the source of such deposits. In FY 2006, \$1.78 billion was deposited with the Department of the Treasury and the Centers for Medicare and Medicaid Services (CMS), transferred to other Federal agencies administering health care programs, or paid to private persons during the fiscal year. The following chart provides a breakdown of the transfers/deposits:

Total Transfers/Deposits by Recipient FY 2006	
Department of the Treasury	
HIPAA Deposits to the Medicare Trust Fund	
Gifts and Bequests	\$30,085
Amount Equal to Criminal Fines	\$143,759,622
Civil Monetary Penalties	\$19,413,407
Asset Forfeiture *	\$0
Penalties and Multiple Damages	\$297,384,495
Subtotal	\$460,587,610
Centers for Medicare & Medicaid Services	
HHS/OIG Audit Disallowances - Recovered	
	\$378,400,000
Restitution/Compensatory Damages	
	\$708,143,083
Subtotal	\$1,086,543,083
Grand Total	\$1,547,130,693
Restitution/Compensatory Damages to Federal Agencies	
Office of Personnel Management	
	\$57,706,781
TRICARE	
	\$14,707,156
HHS/OIG Cost of Audits, Investigations and Compliance	
Monitoring	\$9,022,178
Veteran's Administration	\$5,291,723
Indian Health Services	\$3,245,069
Administration for Children and Families	\$2,589,526
Other Agencies	\$4,641,347
Subtotal	\$97,203,780
Relators' Payments**	\$140,229,514
TOTAL ***	\$1,784,563,987

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

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

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

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

- (1) Gifts and bequests made unconditionally to the Trust Fund, for the benefit of the Account or any activity financed through the Account;
- (2) Criminal fines recovered in cases involving a Federal health care offense, including collections under section 24 (a) of Title 18, United States Code (relating to health care fraud);
- (3) Civil monetary penalties in cases involving a Federal health care offense;
- (4) Amounts resulting from the forfeiture of property by reason of a Federal health care offense, including collections under section 982(a)(7) of Title 18, United States Code; and
- (5) Penalties and damages obtained and otherwise creditable to miscellaneous receipts of the general fund of the Treasury obtained under sections 3729 through 3733 of Title 31, United States Code (known as the False Claims Act, or FCA), in cases involving claims related to the provision of health care items and services (other than funds awarded to a relator, for restitution or otherwise authorized by law).

PROGRAM ACCOMPLISHMENTS

EXPENDITURES

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

FY 2006 ALLOCATION OF HCFAC APPROPRIATION (Dollars in thousands)	
Organization	Allocation
Department of Health and Human Services	
Office of Inspector General ³	\$160,000
Office of the General Counsel	4,778
Administration on Aging	3,128
Centers for Medicare & Medicaid Services (CMS)	22,297
Health Resources and Services Administration	450
Office of the National Coordinator for Health Information Technology (ONC)	490
Subtotal	\$191,143
Department of Justice	
United States Attorneys	\$30,400
Civil Division	14,459
Criminal Division	1,580
Civil Rights Division	1,976
Nursing Home and Elder Justice Initiative	1,000
Subtotal	\$49,415
Total	\$240,558

³In addition, HHS/OIG obligated \$9.02 million in funds received as “reimbursement for the costs of conducting investigations and audits and for monitoring compliance plans” as authorized by section 1128C(b) of the Social Security Act, 42 U.S.C. § 1320a-7c(b).

ACCOMPLISHMENTS

Overall Recoveries

During this fiscal year, the Federal Government won or negotiated approximately \$2.2 billion in judgments and settlements, and it attained additional administrative impositions in health care fraud cases and proceedings. The Medicare Trust Fund received transfers of approximately \$1.5 billion during this period as a result of these efforts, as well as those of preceding years, in addition to \$177.1 million in Federal Medicaid money similarly transferred to the Treasury separately as a result of these efforts⁴.

In addition to these enforcement actions, numerous audits, evaluations and other coordinated efforts yielded recoveries of overpaid funds, and prompted changes in Federal health care programs that reduce vulnerability to fraud. In FY 2006, HHS collected more than \$378.4 million in HHS/OIG recommended recoveries.

Program Accomplishments

Working together, HHS/OIG, DOJ and their law enforcement partners have brought to successful conclusion the investigation and prosecution of numerous health care fraud schemes. During FY 2006, the many significant HCFAC Program accomplishments included the following:

Hospital Fraud

- Tenet Healthcare Corporation, operator of the nation's second largest hospital chain, agreed to pay the United States more than \$900 million for billing practices that were alleged to be unlawful in lawsuits filed by whistleblowers. Under the agreement, Tenet, which is headquartered in Dallas but operates dozens of hospitals throughout the United States, will pay a total of \$900 million over a 4-year period, plus interest, to resolve various types of civil allegations involving Tenet's billings to Medicare and other Federal health care programs.

Of the \$900 million settlement amount, the agreement requires Tenet to pay:

- ▶ more than \$788 million to resolve claims arising from Tenet's receipt of excessive "outlier" payments (payments that are intended to be limited to situations involving extraordinarily costly episodes of care) resulting from the hospitals' inflating their

⁴Note that some of the judgments, settlements, and administrative actions that occurred in FY 2006 will result in transfers in future years, just as some of the transfers in FY 2006 are attributable to actions from prior years.

charges substantially in excess of any increase in the costs associated with patient care, and billing for services and supplies not provided to patients;⁵

- ▶ more than \$47 million to resolve claims that Tenet paid kickbacks to physicians to get Medicare patients referred to its facilities, and that Tenet billed Medicare for services that were ordered or referred by physicians with whom Tenet had an improper financial relationship; and,
 - ▶ more than \$46 million to resolve claims that Tenet engaged in “upcoding,” which refers to situations where diagnosis codes that Tenet is unable to support or that were otherwise improper were assigned to patient records in order to increase reimbursement to Tenet hospitals.
-
- St. Barnabas Health Care System, the largest health care system in New Jersey, paid \$265 million to resolve allegations that nine of its hospitals fraudulently increased charges to elderly patients to obtain enhanced Medicare reimbursement for outlier claims. The United States alleged that between October 1995 and August 2003, Saint Barnabas and nine of its hospitals purposefully inflated charges for inpatient and outpatient care to make these cases appear more costly than they actually were, and thereby obtained outlier payments from Medicare that they were not entitled to receive. Saint Barnabas entered into a Corporate Integrity Agreement (CIA) with the HHS/OIG. The CIA contains measures to ensure compliance with Medicare regulations and policies in the future.
 - Our Lady of Lourdes Regional Medical Center agreed to pay the United States \$3.8 million to settle claims that they defrauded Medicare, TRICARE, and Medicaid from 1999 to 2003. The civil settlement resolves allegations that the Lafayette, Louisiana, facility submitted claims for medically unnecessary angiogram, angioplasty, and stenting procedures that were performed at the hospital from 1999 to 2003. The allegations arose from a lawsuit filed by a whistleblower at the hospital.
 - Beth Israel Medical Center in New York City paid \$73 million to resolve allegations that it submitted false claims for Medicare reimbursement in cost reports from 1992 to 2001. The Government alleged that Beth Israel misrepresented information related to the operating costs of its Kings Highway Division in Brooklyn and improperly claimed certain nonreimbursable costs. These costs included the costs of private offices for Beth Israel’s faculty physicians, overhead for its methadone maintenance treatment program, fund-raising and marketing costs, and staff living quarters already paid for through rent collected from Beth Israel employees. The settlement resulted in part from a voluntary disclosure by Beth Israel and in part from a qui tam suit filed by a relator.

⁵Congress enacted the supplemental outlier payment system to defray a portion of the costs to care for the very sickest patients, where reimbursement under the prospective payment system falls far short of the hospital’s actual cost to care.

- Following a three-week trial, the former owner and chief executive officer of the now defunct Edgewater Hospital in Chicago, was found liable under the FCA for engaging in an illegal kickback scheme at Edgewater. The court found that the defendant paid physicians for Medicare and Medicaid patient referrals in violation of federal law. The court held that the hospital's cost reports and individual patient claims for patients referred in connection with the scheme were false claims, and awarded treble damages and penalties on just over 1,800 claims.
- Two owners of a former San Diego psychiatric hospital were found liable after trial for more than \$15.7 million in damages and penalties for having included false claims in the hospital's cost report submitted to the Medicare program. Those cost reports sought reimbursement from the Medicare program for a variety of false costs, such as amounts for a fictitious lease, reimbursement for unused hospital space, and millions of dollars in costs that were actually attributable to the defendants' business enterprises unrelated to that hospital. The court awarded the United States \$15.7 million for treble damages and \$31,000 in civil penalties.
- University Hospitals Health System (UH) in Ohio paid the United States \$13.8 million to resolve allegations that UH violated the FCA. The payment resolved a qui tam suit brought by a physician formerly affiliated with UH, who alleged that UH entered into illegal financial arrangements with physicians in order to induce referrals to UH for services reimbursable by Medicare.
- Chattanooga-Hamilton County Hospital Authority, the public nonprofit corporation that owns and operates Erlanger Medical Center located in Chattanooga, Tennessee, paid \$37 million to the United States and \$3 million to Tennessee to settle claims that Erlanger paid money and other compensation, directly or indirectly, intended to induce physician referrals to its facilities in violation of the Anti-kickback Statute.
- The Milton S. Hershey Medical Center paid the United States \$2.9 million to settle allegations that it improperly submitted infusion therapy claims despite having been notified on five separate occasions that it was submitting its bills for these services improperly. This settlement was part of a joint project in Pennsylvania between the United States Attorney's Offices and the HHS/OIG to investigate whether Pennsylvania hospitals submitted erroneous infusion therapy and/or blood transfusion claims to the Medicare Program which has resulted in numerous settlements and the return of over \$8 million to the Medicare Program.

Pharmaceutical Fraud

- The Swiss corporation Serono, S.A., one of the world's largest biotech manufacturers, paid \$704 million to resolve criminal charges and civil liabilities in connection with several illegal schemes to promote and sell its drug, Serostim, that resulted in the submission of false claims to Medicaid and other federally funded health care programs. The Food and Drug Administration (FDA) had granted accelerated approval for Serostim in 1996 to treat Auto-Immune Deficiency Syndrome (AIDS) wasting, a condition involving profound involuntary weight loss in AIDS patients, then a leading cause of death in AIDS patients. Following the advent of protease inhibitor drugs, the incidence of AIDS wasting markedly declined, and Serono launched a campaign to redefine AIDS wasting to create a market for Serostim. While doctors are permitted to prescribe drugs for uses that are not approved by the FDA, pharmaceutical companies are prohibited from marketing drugs for unapproved, or "off-label" uses.

Serono pled guilty to conspiring with RJL Sciences, a medical device manufacturer, to introduce on the market bioelectrical impedance analysis (BIA) computer software packages for use in measuring body cell mass and diagnosing AIDS wasting. The FDA had not approved the BIA software packages for these uses. RJL and its owner also pled guilty to their roles in the conspiracy. In addition, Serono pled guilty to conspiring to offer doctors kickbacks in the form of free trips to Cannes, France, to induce them to prescribe Serostim.

The \$704 million Serono settlement consisted of \$305 million (plus accrued interest) paid by Serono to resolve FCA allegations that it knowingly caused the submission of claims for Serostim that were not eligible for reimbursement because they were for unnecessary or unapproved uses and because the claims were for prescriptions induced by kickbacks to physicians and pharmacies. It also included \$262 million plus interest paid to state Medicaid programs, as well as \$136.9 million in criminal fines.

- Schering-Plough Corporation, together with its subsidiary, Schering Sales Corporation, agreed to pay a total of \$435 million to resolve criminal charges and civil liabilities in connection with illegal sales and marketing programs for its drugs Temador, used in the treatment of brain tumors and metastasis, and Intron A, used in the treatment of superficial bladder cancer and hepatitis C.

Schering Sales Corporation agreed to plead guilty to charges that it conspired with others to make false statements to the FDA in response to the FDA's inquiry concerning certain illegal promotional activities by the company's sales representatives at a national conference for oncologists. Schering Sales also agreed to plead guilty to charges that it conspired with others to give free Claritin Redi-Tabs to a major health maintenance organization (HMO) to disguise a new lower price being offered to the HMO to obtain its business.

As part of the civil resolution, Schering-Plough Corporation agreed to pay \$255,025,000 to resolve civil False Claims Act liabilities and liabilities under the Food Drug and Cosmetic Act in connection with illegal sales and marketing programs for its drugs Temodar for use in the treatment of brain tumors and Intron A for use in treatment of superficial bladder cancer and hepatitis C. The civil resolution also resolves allegations of Medicaid Drug Rebate fraud involving Schering's drugs Claritin RediTabs, and K-Dur, used in treating stomach conditions.

- King Pharmaceuticals, Inc., paid \$75 million to resolve allegations that it underpaid rebates owed under the Medicaid program. King paid an additional \$50 million to several state governments based on the same allegations. The settlement addressed King's alleged understatement of its drugs' "average manufacturer price" and overstatement of its lowest available price or "best price". For certain drugs, pharmaceutical companies are required to report their best price to Medicaid and to rebate the difference between the average manufacturer price and their best price. By understating the former and overstating the latter, King unlawfully reduced its obligation to pay rebates in violation of the Medicaid program.
- Eli Lilly and Company agreed to plead guilty and to pay \$36 million in connection with its illegal promotion of its pharmaceutical drug Evista. In addition to the criminal plea, Lilly agreed to settle civil Food, Drug, and Cosmetic Act liabilities by entering into a consent decree of permanent injunction and paying the United States \$24 million in equitable disgorgement.

Evista is approved by the FDA for the prevention and treatment of osteoporosis in postmenopausal women. The Government alleged that the first year's sales of Evista in the U.S. were disappointing compared to Lilly's original forecast; the company reduced the forecast of Evista's first year's sales in the U.S. from \$401 million to \$120 million. In order to expand sales of the drug, it was alleged, Lilly sought to broaden the market for Evista by promoting it for off-label uses, such as for the prevention and reduction in risk of breast cancer, and the reduction in the risk of cardiovascular disease. Lilly promoted Evista as effective for reducing the risk of breast cancer, even after Lilly's proposed labeling for this use was specifically rejected by the FDA.

- Omnicare, Inc., the nation's leading provider of pharmacy services to skilled nursing facilities and assisted living communities, in a case jointly investigated by the Department of Justice, several Federal law enforcement agencies and the National Association of Medicaid Fraud Control Units (NAMFCU), agreed to pay the United States and 42 states \$49.5 million to settle Medicaid prescription-drug-fraud claims initiated by two whistleblowers. Omnicare substituted different versions of prescribed drugs (such as tablets for capsules) solely to inflate profits rather than for any legitimate medical reason, and, as part of the settlement, Omnicare has also entered into a CIA with the HHS/OIG that is designed to prevent this type of drug switch in the future.

- Doing business as Glaxo SmithKline, SmithKline Beecham Corporation agreed to pay the Government \$149 million plus interest and enter into a 5-year addendum to its existing CIA with the HHS/OIG. The settlement resolved allegations that the pharmaceutical manufacturer engaged in certain improper pricing and marketing practices for Zofran and Kytril, two antiemetic drugs used primarily in conjunction with oncology and radiation treatment.

Nursing Home Fraud

- Horizon West, Inc., and its wholly owned subsidiary, Horizon West Healthcare, Inc., have agreed to pay the United States \$14.7 million to settle allegations that the companies violated the civil FCA by falsely inflating the number of nursing hours spent on Medicare patients. Horizon West runs a nursing home chain with approximately 30 facilities in California and Utah.
- American Healthcare Management, Inc., (AHM), its individual owners, and three affiliated nursing homes agreed to pay \$1.25 million to settle allegations of submitting false and fraudulent nursing home billings to Medicare and Medicaid for poor quality of care. The United States alleged that due to staffing limitations, numerous residents of the nursing homes suffered from dehydration and malnutrition, went for extended periods of time without cleaning or bathing, and contracted preventable pressure sores. In addition, instances of elopements of residents from the facilities occurred, a resident was found covered with ants, and a resident was physically abused by a staff member. As part of the settlement, AHM and the three nursing homes agreed to permanent exclusions, and the principal owner agreed to a 20-year exclusion. The other owner agreed to certify annually that he had no involvement in Medicare or Medicaid, and that if he did opt to bill those programs, he agreed that he would enter into a CIA at that time.
- Life Care Centers of America, Inc., (LCCA) the operator of a Georgia-based skilled nursing facility known as Life Care Center of Lawrenceville (Lawrenceville), along with Lawrenceville's owners Gwinnett Medical Investors Limited Partnership, Developers Investment Company, Inc., and the founder of LCCA, agreed to pay a total of \$2.5 million to resolve multiple allegations of FCA violations for billing for services that either were not provided to the Lawrenceville residents or were deficient. The complaint, originally filed by five whistleblowers in November 2002, alleged a systemic failure by Lawrenceville to provide appropriate nursing care to its residents and also alleged that such failure resulted in the premature deaths of several residents. It was alleged that the failure of care was the result of severe under staffing, inadequate staff training, high staff turnover, an ineffective medical director, poor nursing documentation, and insufficient budgetary allowances. The whistleblowers all had family members who were residents at Lawrenceville.

LCCA and Lawrenceville entered into a CIA which, among other things, required the appointment of an independent monitor who will oversee operations at Lawrenceville for up to five years to verify that patients receive appropriate care. LCCA also agreed to apply the policies and procedures implemented for Lawrenceville to LCCA's other facilities across the country.

- USA Healthcare, Inc., (USAH) the owner of several skilled nursing facilities based in Cullman, Alabama, settled allegations of overcharging Medicare by agreeing to pay the United States \$1.2 million. The investigation arose out of an audit of cost reports filed by several of USAH's skilled nursing facilities which revealed that the company violated Medicare rules by failing to disclose that certain vendors were related to USAH by common ownership or control and therefore should have been reimbursed by Medicare at a lower rate based on actual costs and without inclusion of profit.

Durable Medical Equipment Fraud

- In Houston, a jury convicted a Texas osteopath on 13 counts related to health care fraud. The osteopath was sentenced to 10 years in prison, and ordered to pay \$7.9 million in restitution to Medicare and Medicaid. The osteopath never obtained a license to practice in Texas. Nevertheless, over a 2-year period beginning in 2002, the osteopath signed pre-printed prescriptions and certificates of medical necessity (CMNs) for motorized wheelchairs in exchange for payments from marketers of durable medical equipment (DMEs). The osteopath rarely examined the Medicare and Medicaid beneficiaries in whose names the prescriptions and CMNs were prepared. The marketers, in turn, sold the signed documents to DME suppliers in Texas and elsewhere. The osteopath's fraudulent activity has been linked to nearly \$8 million in Medicare and Medicaid payments.
- In Tennessee, an individual was sentenced to 23 months in prison and ordered to pay \$1.8 million in restitution for his role in a scheme to defraud Medicare. As the self-described "ring leader," the defendant recruited friends and family members to establish DME suppliers with different names. These suppliers billed Medicare for enteral nutrition products that were never actually provided to any beneficiaries. In some instances, the suppliers provided only flavored milk products to the elderly but billed Medicare as if the companies were providing enteral nutrition. This defendant was the seventh co-conspirator to be convicted as a part of "Project Milk Man."
- In Texas, the owner of a DME supplier plead guilty and was sentenced to 63 months in prison for the fraudulent billing of expensive motorized wheelchairs and other DME. The owner paid recruiters to collect Medicare and Medicaid beneficiary numbers and other information in Texas and in surrounding states. The owner then used the patient information to bill Medicare or Medicaid for DME, while providing less expensive products to the named beneficiaries, or none at all. Through this scheme, the owner was paid \$1.6 million by Medicare and Medicaid. In addition to the prison sentence, the owner was ordered to pay \$669,000 in restitution.

- In Florida, a licensed orthotist and a patient recruiter were sentenced for conspiring to commit health care fraud involving eight Miami-based medical organizations. The orthotist was sentenced to 28 months in prison and ordered to pay \$1.8 million in restitution for providing DME suppliers with signed CMNs and prescriptions for orthotic devices without having examined the named Medicare beneficiaries. He paid the beneficiaries for the misuse of their personal information. The DME companies then billed for expensive custom-fitted devices, but provided only prefabricated devices. The patient recruiter was sentenced to 22 months in prison and ordered to pay approximately \$4.2 million in restitution.
- Beverly Enterprises, Inc., agreed to pay the United States and the state of California \$20 million to settle allegations that its former wholly-owned subsidiary, MK Medical, submitted false claims to the Medicare and Medi-Cal programs from 1998 until 2002, while Beverly owned the company. MK Medical, a now-defunct wholesaler of DME, allegedly billed Medicare and Medi-Cal for DME provided to the programs' beneficiaries without obtaining the proper medical documentation. Beverly has agreed to settle these allegations by paying \$14.5 million to the United States and \$5.5 million to the state of California.
- The owner of a power wheelchair store was sentenced to 63 months in prison and ordered to pay over \$4 million in restitution to the Medicare and Medicaid programs after he was convicted by a jury of paying recruiters to take beneficiaries to a medical clinic where a physician would perform medically unnecessary procedures and then sign false CMNs authorizing the beneficiaries to receive motorized wheelchairs. The physician also was sentenced to 11 years and three months in prison for his participation in the scheme, for receiving payment for signing the CMNs, and for submitting claims for services that either weren't performed properly, or were not performed at all.
- In Texas, the owner of a power wheel chair store, the owner's brother and a physician were found guilty of paying and receiving illegal kickbacks, and money laundering after a four week jury trial in San Antonio. The owner paid recruiters to find Medicare beneficiaries. The owner then paid the physician to falsely certify medical necessity of scooters or K0011 power wheelchairs. The owner would then fraudulently bill the Medicare program for reimbursement regardless of what, if any, equipment had been provided. Under the scheme, the defendants billed Medicare in excess of \$12 million. The owner was sentenced to 151 months, the owner's brother received 66 months and the physician was sentenced to 54 months imprisonment.
- In the Southern District of Texas, a physician was sentenced to 10 years in prison for conspiring to defraud Medicare of \$30 million in a wheelchair scam. The physician and the physician's office manager sold CMNs and prescriptions for motorized wheelchairs and other durable medical equipment to certain marketers and suppliers for approximately \$200 each. Nearly all of the physician's "patients" were ineligible for these items. They also sold prescriptions for controlled substances that were outside the normal course of

medical practice and were not medically necessary. They wrote 17,086 such prescriptions and received no less than \$1.7 million in cash.

- In the Southern District of Texas, the owner of a Houston-based DME company was sentenced to 63 months in prison for the owner's role in a motorized wheelchair scam. The company fraudulently billed Medicare and Medicaid for almost \$5 million and defrauded these health care programs of at least \$1.6 million.

Ambulance Services Fraud

- In North Carolina, an ambulance company and its owner were convicted of billing Medicare and Medicaid for dialysis patient transports that were not medically necessary. The owner was sentenced to 120 months in jail for health care fraud and to an additional 31 months in jail for obstruction. The company and the owner were also ordered to pay \$604,000 in joint-and-several restitution. The company owner instructed emergency medical technicians to enter information on ambulance reports that falsely indicated that patients required transportation by ambulance when, in fact, they could have been transported by other means. To conceal this activity, the owner and the billing manager altered records to indicate medical necessity. The billing manager was previously sentenced and was ordered to pay \$30,000, a portion of the joint-and-several restitution amount.
- American Medical Response Inc. (AMR), one of the nation's largest ambulance providers, paid the United States over \$9 million to resolve allegations that the company violated the FCA. The Government alleged that the ambulance company provided illegal inducements to hospitals in Texas in exchange for referrals. The settlement relates to allegations that AMR, based in Greenwood, Colorado, provided or offered inducements to Texas hospitals in the form of contracts known as "swapping arrangements." Such contracts gave the medical facilities discounts on transports in exchange for the referral of patients upon their discharge from the hospitals.

Chiropractic Fraud

- A former Indiana chiropractor was sentenced to 12 years and 6 months in prison, and ordered to pay \$1.5 million in restitution, for billing Medicare, Medicaid, and private insurers for medically unnecessary back braces. The former chiropractor would arrange for presentations at senior citizens centers and other locations, often recruiting children to distribute flyers advertising the presentation in return for movie tickets. At the presentations, the chiropractor would distribute the back braces, valued at less than \$100 each, to senior citizens and the indigent irrespective of need. The chiropractor would then bill government or private health insurers \$1,300 for each brace.

Podiatry Fraud

- An Illinois podiatrist was sentenced to death for the murder of a grand jury witness, sentenced to 78 months in prison for health care fraud, and ordered to pay \$1.8 million in restitution. A jury convicted and condemned the podiatrist to death for murdering a woman days before she was expected to testify before the grand jury about the more than 70 foot surgeries that were not performed that the podiatrist billed to Medicare.
- An Ohio podiatrist was sentenced to 78 months in prison for conspiring and scheming to defraud Medicare. Because the podiatrist defaulted on federal student loans, Medicare excluded the podiatrist in 2000, thus prohibiting billing Medicare for podiatry services. Despite this, the podiatrist continued to bill Medicare under a corporate name. The corporation used the names of former podiatry school classmates, including one who was, at the time, dying of cancer. None gave the podiatrist permission to use their names. In 2002, the podiatrist persuaded the Government to lift the exclusion, and began billing Medicare for complex procedures, when only routine nail-trimming services were provided. In addition to prison time, the podiatrist was ordered to pay \$528,000 in restitution.

Fraud by Physicians

- An Ohio pain management physician was sentenced to life in prison, plus an additional 20 years, for two charges of health care fraud resulting in death in addition to other charges of health care fraud. The Ohio physician administered to all his patients unnecessary and painful “trigger-point” injections of Schedule II and III narcotics. Once addicted, his patients would return for weekly injections, and were often forced to contribute to a “malpractice insurance fund.” In two instances, the injections lead to fatal drug overdoses. The physician submitted \$60 million in fraudulent bills to health care benefit programs, claiming he was performing multiple, complex epidural and nerve block injections when, in fact, he performed crude versions of lower cost trigger-point injections. In addition to the prison sentence, he was ordered to pay \$14.3 million in restitution to Medicare, Medicaid, and the Ohio Bureau of Workers Compensation. The health care fraud resulting in death case was recognized as the Investigation of the Year for 2006 by the National Health Care Anti-Fraud Association.
- A Tennessee oncologist was sentenced to over 15 years imprisonment for defrauding Medicare, TennCare and BlueCross BlueShield at the expense of cancer patients. The defendant administered diluted versions of chemotherapy medications to patients, and instructed nurses to draw up partial doses of other medications to administer to patients.
- From 1996 through 2003, a physician employed an individual to work at the physician’s medical practice in Connecticut. Although the individual was not licensed to practice medicine, the individual nonetheless treated patients in the physician’s medical practice. During this time, the individual was referred to as "Doctor" by the physician and wrote

prescriptions. The physician then billed insurance companies for services that were rendered by the individual, representing them as services rendered by a physician. They both pled guilty to conspiracy to commit health care fraud and was sentenced to two months of imprisonment, four months of home confinement and three years of supervised release. The physician also entered into a civil settlement with the Government and paid \$160,000.

- A jury convicted a Manhattan dermatologist for unlawfully distributing prescription narcotics and for health care fraud. The dermatologist was sentenced to 20 years imprisonment and was ordered to pay \$880,000 in restitution. From 1992 to 2002, the dermatologist engaged in a pattern of fraudulent behavior that ultimately led to the death of one individual. The dermatologist paid kickbacks, often in the form of medically unnecessary prescriptions for controlled or addictive substances, to induce beneficiaries to continue returning to his office. The dermatologist would then bill Federal or private health plans for the visit and for services not provided. The dermatologist filed almost 2,000 claims for surgeries allegedly performed on a single patient, ultimately receiving \$425,000 in reimbursements. By submitting these claims, the dermatologist certified that, among other procedures, 1,300 4 centimeter incisions were performed in this one patient's face. Ultimately, this individual's participation in the scheme proved fatal, as the patient overdosed on Dilaudid and Carisprodol, which were regularly obtained from the dermatologist.

Fraud by Other Practitioners

- In Illinois, a dentist was sentenced to 63 months in prison and ordered to pay \$827,000 in restitution and a \$20,000 fine. The dentist was found guilty in a jury trial on charges of mail fraud and health care fraud. The dentist performed unnecessary dental procedures on patients and billed for services not performed or not performed as indicated.
- The owner of Indiana-based dental practice, The Smile Center, and the owner's mother pled guilty to health care fraud. It was alleged that The Smile Center defrauded the Indiana Medicaid Program by billing for services that were either not medically necessary or were not provided at all, and for coding services to appear as if they were covered by Medicaid when they were not. Their scheme resulted in losses of over \$1.8 million which the defendants agreed to repay in a related civil settlement.
- A Kansas couple was convicted on Federal charges for involuntary servitude, forced labor, conspiracy, health care fraud, and mail fraud. The social worker and his wife, a nurse, were sentenced to 30 years and 7 years in prison, respectively, and ordered to pay approximately \$500,000 in joint-and-several restitution. In addition, the jury ordered the couple to forfeit approximately \$85,000 and four properties. For over 24 years, the couple operated a group home that provided "therapy" for mentally ill patients. The investigation revealed that the social worker forced and coerced his patients to perform manual labor in the nude and participate in therapy sessions that involved sexually explicit acts. The

man's wife helped enforce house rules and fraudulently billed Federal health care programs.

- A California audiologist was sentenced to 78 months in prison for defrauding Medicare and Medi-Cal. From January 1997 through July 2003, the audiologist billed Medicare and Medi-Cal for hearing aids, speech therapy, and other related services without being licensed to dispense or render the service and, in most cases, without a prescription from a referring physician. The audiologist also billed for services purportedly provided to deceased beneficiaries. In addition to the prison sentence, the audiologist was ordered to pay \$868,000 in restitution.

Infusion Therapy

- In FY 2006, the United States Attorney for the Southern District of Florida, the Civil Division, the FBI, the HHS/OIG, CMS, and Florida state enforcement agencies worked together in a federal-state fraud task force to aggressively address the problem of fraud by human immunodeficiency virus (HIV) and other specialized medical clinics in South Florida. Over the year, twenty-three defendants were charged in matters relating to fraud arising in clinics ostensibly providing infusion therapy to persons with HIV. The investigation determined that in many instances the so-called clinics were nothing more than mailing addresses where no medical services were provided. It determined also that, in some instances, beneficiaries were paid modest sums to attend clinics and undergo infusion therapy that later was billed to Medicaid or Medicare. The task force utilized the Miramar Health Care Facility, a Department of Justice document storage and investigative support facility located in Broward County, Florida. The following are illustrative of the cases brought:

A physician and his medical assistant in Miami, and three other defendants who participated in a health care fraud scheme involving a Miami HIV/AIDS clinic, were convicted after a jury trial and sentenced to imprisonment for billing Medicaid \$1.3 million for medications and treatments that were not administered to Medicare beneficiaries with HIV and for paying the beneficiary patients kickbacks to attend the clinic.

Two employees of Project New Hope, a medical clinic located in Miami that claimed to specialize in the treatment of Medicare beneficiaries with HIV, were found guilty by a jury for participating in a fraudulent scheme that billed at least \$2.8 million in medications that most of the beneficiaries did not receive, and for paying kickbacks to the beneficiaries to get them to attend the clinic. Five other defendants pled guilty before trial.

Medicare Secondary Payer⁶

- Highmark, Inc., settled allegations that the Pennsylvania insurance company underpaid the amounts due for the care of certain Medicare beneficiaries under the employer group health plans administered by the company. Highmark voluntarily conducted a review to capture actual employee count data from its customer employers for purposes of determining whether Medicare should be the primary or secondary payer. Based on the results of this review, Highmark refunded \$2.5 million to Medicare. Highmark also paid an additional amount of approximately \$2 million to the Government and agreed to implement a model Medicare Secondary Payer (MSP) program to address how data regarding employee counts is captured and utilized. The terms of the settlement require that an independent organization will verify that Highmark establishes and maintains MSP procedures consistent with the model.

Child Vaccine Programs

- Operation Free Shot focuses on Connecticut health care providers who bill Medicaid and other insurance programs for childhood vaccines the providers received free-of-charge from the Vaccines For Children (VFC) program, a joint Federal and state program that provides childhood immunizations. Under the VFC Program, doctors and other health care providers receive free vaccines distributed by the Department of Public Health and agree not to bill Medicaid or any other third-party for the cost of the vaccines. The provider may recover a minimal fee for administrative costs associated with inoculating a child. Overall, there have been seven civil settlements and two criminal convictions, with a total recovery of in excess of \$2 million, and in FY 2006 there were two civil settlements against a physician and Winstead Pediatrics in the amount of \$430,000.
- The District of Utah also has investigated the VFC program and has entered into four settlements with providers over the last three years and one in FY 2006 against a physician in the amount of \$53,000.

Drug Diversion and Internet Pharmacy Fraud

- An Arizona resident obtained more than 27,000 pills, mostly Percocet and Oxycodone, from 51 Tucson area pharmacies using forged signatures. The individual pled guilty to health care fraud and other felonies of conspiracy, possession with intent to distribute a controlled substance, possession of a controlled substance by misrepresentation, fraud, forgery, deception and subterfuge, and fraud in connection with identification documents.

⁶Medicare is a secondary payer of medical costs for its beneficiaries who are current employees of an employer with 20 or more employees, or of an employer of 19 or fewer employees who is a member of a multiple employer plan or a group health plan (GHP) who has at least 1 member with 20 or more employees. Medicare dictates that the employer or GHP, not Medicare, is responsible for primary payment of the claims.

- A Minnesota resident was convicted by a jury of illegally selling prescription drugs and controlled substances over the Internet. The individual was responsible for the distribution of more than two million units of Schedule III controlled substances with a value of approximately \$24 million. Five other individuals, including the prescribing physician, have also pled guilty to Federal felonies and are awaiting sentencing.

- Seventeen individuals and thirty-seven corporations pled guilty in San Antonio to, among other things, health care fraud, distribution and possession with intent to distribute a controlled substance, and money laundering. The indictment alleged that the defendants sold controlled substances, including hydrocodone, phentermine hydrochloride, alprazolam, and promethazine cough syrup containing codeine, over the Internet without any controls. It was alleged that more than \$200 million in pharmaceuticals was fraudulently purchased from commercial pharmaceutical wholesalers and diverted for fraudulent and illegal distribution.

- A Florida pharmaceutical wholesale distributor with offices in Miami, Savannah, and elsewhere, bought and sold millions of dollars of fraudulently obtained prescription drugs, including drugs already paid for by the Florida and California state Medicaid Programs; drugs defrauded from the Immune Deficiency Foundation's Safety Net Program; and drugs defrauded from several pharmaceutical manufacturers and distributors. The defendants were convicted for the unlawful purchase and sale of prescription drugs, primarily blood derivatives used in the treatment of cancer, AIDS, hemophilia and other critical care illnesses. The defendants received sentences as high as 300 months in prison, fines as high as \$5 million, and were ordered to pay \$27.8 million in restitution.

- In the Southern District of Texas, an individual pled guilty to counterfeit labeling and false trademarks on pharmaceutical drugs. Eleven individuals, including the defendant's alleged supplier, were arrested in China and charged with manufacturing and distributing counterfeit Viagra, Cialis and Lipitor. Subsequent searches resulted in the seizure of equipment used to process counterfeit pharmaceuticals, 600,000 counterfeit Viagra labels and packaging, 440,000 counterfeit Viagra and Cialis tablets, and 260 kilograms of raw materials used to manufacture counterfeit pharmaceuticals.

- In the Western District of New York, a pharmacist pled guilty in connection with the theft of approximately \$1,875,000 in public and private health care insurance funds. The pharmacist submitted claims to Medicaid and private health insurers for prescription refills that were not authorized by the prescribing physician; name brand drugs when the generic drug was provided; prescriptions that were never actually filled; and other fraudulent prescriptions.

- In the Northern District of Iowa, two doctors employed by a corporation that owned Internet pharmacy web sites were each sentenced to 20 months in prison for conspiring to

dispense Schedule III and Schedule IV controlled substances without a legitimate medical purpose and outside the usual course of medical practice. Another conspirator was sentenced to three years of probation, with a six-month term of home confinement as a special condition. The defendants admitted they were employed by the corporation to review the questionnaires and approve the prescription drug requests though none had ever examined any of the “patients” before prescribing thousands of dosage units of Schedule III controlled substances, usually pain narcotics.

Hospice Fraud

- Odyssey HealthCare, a national hospice provider, paid the United States \$12.9 million to settle allegations that the company submitted false claims to Medicare. The Dallas-based company is alleged to have billed Medicare for services provided to hospice patients who were not terminally ill and therefore were ineligible for the Medicare hospice benefit. The settlement, which covers a period from 2001 to 2005, also resolves charges originally brought against Odyssey HealthCare in a qui tam action brought by a former regional vice president. As part of the settlement, the former vice president will receive \$2.3 million for bringing the matter to the attention of the Government. Odyssey HealthCare also entered into a CIA with the HHS/OIG. The CIA addresses the company’s practices regarding compliance with applicable Medicare regulations.
- Faith Hospice, Inc., settled allegations that it submitted fraudulent claims to Medicare and Medicaid for hospice care. The investigation was initiated when a review of a sample of Faith Hospice’s medical records showed that more than half of its patients were ineligible for hospice care. Under the agreement, the owner and Faith Hospice forfeited approximately \$599,000 to the United States, one half of the funds seized pursuant to the civil forfeiture action.

Kickbacks

- Lincare Holdings, Inc., and its subsidiary, Lincare, Inc. (collectively, Lincare), agreed to pay the Government \$10 million and to enter into a 5-year company-wide CIA. The settlement resolves allegations that Lincare violated the anti-kickback provision of the Civil Monetary Penalties Law (CMPL) and the Physician Self-Referral Law. The HHS/OIG alleged that from January 1993 through December 2000, Lincare engaged in a nationwide scheme to pay remuneration to physicians to induce referrals of patients to Lincare for DMEs. The HHS/OIG alleged that Lincare gave referring physicians items such as sporting and entertainment tickets, gift certificates, golf rounds and equipment, fishing trips, meals, advertising expenses, office equipment, and medical equipment, as well as payments pursuant to purported consulting agreements. The HHS/OIG also alleged that Lincare violated the Physician Self-Referral Law by accepting referrals from parties to the purported consulting agreements.

- Medtronic, Inc., agreed to pay the United States \$40 million to settle civil allegations that its Medtronic Sofamor Danek division (MSD) paid kickbacks to doctors to induce them to use MSD's spinal products. The Government alleged that, between 1998 and 2003, Medtronic paid illegal kickbacks in a number of forms, including sham consulting agreements, sham royalty agreements and lavish trips to desirable locations. The Government's investigation was triggered by the filing of a qui tam action.

- Marion Regional Health Care System agreed to pay the United States \$3.75 million to resolve allegations of health care fraud against the Government. The settlement resolves allegations that Marion County Medical Center submitted false claims to Medicare, Medicaid and TRICARE by engaging in financial relationships with certain physicians that were prohibited under the Physician Self-Referral Law and/or the Anti-kickback Statute. Specifically, the settlement focuses on the compensation Marion paid to two physicians which the United States contends far exceeded the fair market value of the services provided by those physicians and was not commercially reasonable. The settlement also resolves allegations that Marion submitted claims to Medicare for professional services for initial hospitalizations which were coded at a level higher than the services that were provided. The United States initiated the investigation in response to a whistleblower action brought by a former employee of Marion.

Page intentionally left blank

FUNDING FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General

Certain of the funds appropriated under HIPAA are, by law, set aside for Medicare and Medicaid activities of the HHS/OIG. In FY 2006, The Secretary and the Attorney General jointly allotted \$160 million to the HHS/OIG which is the statutory maximum permitted under HIPAA.

The HHS/OIG participated in investigations or other inquiries that resulted in 744 prosecutions or settlements in FY 2006, of which 567 or 76% percent were health care cases. A number of these are highlighted in the Accomplishments section. During FY 2006, the HHS/OIG also excluded a total of 3,422 individuals and entities, barring them from participating in Medicare, Medicaid, and other Federal and state health care programs. In addition, the Department of Health and Human Services collected more than \$378.4 million in disallowances of improperly paid health care funds, based on HHS/OIG recommendations.

Program Savings

Frequently, investigations, audits and evaluations reveal vulnerabilities or incentives for questionable or fraudulent financial practices in agency programs or administrative processes. As required by the Inspector General Act, the HHS/OIG makes recommendations to agency managers to address these vulnerabilities. In turn, agency managers recommend legislative proposals or other corrective actions that, when enacted or implemented, close loopholes and reduce improper payments or conduct. The net savings from these joint efforts toward program improvements can be substantial. During FY 2006, the HHS/OIG estimates that such corrective actions resulted in health care savings (i.e., funds put to better use as a result of implemented legislative or other program initiatives) of approximately \$34 billion -- \$25.52 billion in Medicare savings, and \$8.48 billion in savings to the Medicaid program. Additional information about savings achieved through such policy and procedural changes may be found in the HHS/OIG Semiannual Report, on-line at <http://oig.hhs.gov/reading/semiannual.html>.

Exclusions

One important mechanism for safeguarding the care provided to program beneficiaries is through exclusion of providers and suppliers who have engaged in patient abuse or neglect or fraud. During FY 2006, the HHS/OIG excluded a total of 3,422 individuals and entities. Among these were exclusions based on criminal convictions for crimes related to Medicare or Medicaid (605), or to other health care programs (245); for patient abuse or neglect (295); or as a result of licensure revocations, suspensions or surrenders (1,868). This list is not meant to be exhaustive,

but identifies the most prevalent causes underlying the HHS/OIG's exclusions of individuals or entities in FY 2006. Among those excluded by the HHS/OIG from participation in Medicare, Medicaid, and other Federal health care programs were the following:

- South Beach Community Hospital (formerly South Shore Hospital and Medical Center) was excluded from participation in Medicare, Medicaid, and other Federal health care programs. The exclusion resulted from South Beach's material breach of the terms of a CIA the hospital negotiated with the HHS/OIG in 2002 as part of the resolution of a FCA case against the hospital. The HHS/OIG determined that South Beach was in material breach for its repeated failure to submit timely, complete, and accurate required reports, and its failure to implement fully the Independent Review Organization requirements of the CIA. South Beach also neglected to notify the HHS/OIG, as required under the CIA, of its sale to new owners, who are also subject to the terms of the CIA. The HHS/OIG determined that South Beach's "repeated and egregious failure" in this case to abide by the terms of its CIA required the HHS/OIG for the first time to seek exclusion for such a violation.
- A registered nurse was excluded for a minimum of 60 years based on her conviction for deliberately and intentionally causing the death of a home health patient under her care, and for using the victim's credit card to obtain cash and make purchases. The registered nurse was ordered to serve a life sentence without parole for first-degree homicide. In addition, she was sentenced to 30 years for aggravated robbery against an at-risk adult, 6 years for theft, and 3 years for unauthorized use of a credit card.
- Another nurse was excluded for a minimum period of 25 years based on his conviction for rape. While providing in-home care, the nurse engaged in sexual intercourse with a female patient incapable of giving consent. The victim is a quadriplegic who is developmentally disabled and suffers from spastic cerebral palsy. The nurse was sentenced to 102 months incarceration and the state revoked his nursing license.
- A pharmacist was excluded for a minimum period of 5 years based on his conviction on multiple counts of battery. During a 15-month period, the pharmacist falsely represented that he was participating in a blood study. The pharmacist paid between \$10 and \$20 per blood sample, which he obtained from women in the community. The pharmacist drew their blood in the pharmacy after hours, in the pharmacy parking lot, in his home, or at the victims' homes.

Other Administrative Enforcement Actions – Civil Monetary Penalties

The Office of Inspector General has authority to impose civil monetary penalties (CMPs) against providers and suppliers who knowingly submit false claims to the Government, who participate in unlawful patient referral or kickback schemes, who fail to appropriately treat or refer patients who

present at hospital emergency rooms, or who engage in other activities prescribed in statute. The HHS/OIG has stepped up its affirmative enforcement actions under these authorities. The Lincare case discussed previously is one example. Others are:

- University of Medicine and Dentistry of New Jersey (UMDNJ) agreed to pay \$2 million to resolve its liability under the HHS/OIG Civil Monetary Penalties Law (CMPL) provisions applicable to false and fraudulent claims. The HHS/OIG alleged that UMDNJ employed two individuals that UMDNJ knew or should have known had been excluded from participation in Federal health care programs. As part of the agreement, UMDNJ is required to submit to the HHS/OIG an annual certification for three years attesting that they have in place a policy for screening all current and prospective employees and contractors to ensure that they are not excluded.
- After it self-disclosed conduct to the HHS/OIG, Inova Health Care Services d/b/a Inova Fair Oaks Hospital (Inova) agreed to pay \$714,000 and to enter into a certification of compliance agreement to resolve its liability under the CMPL provisions applicable to kickback and self-referral law violations. The HHS/OIG alleged that from 1998 to 2004, Inova subleased space in one of its medical office buildings to physicians at rental rates that were below the fair market value. In one instance, a physician benefitted substantially by not paying rent from 1999 through 2004.

Studies, Audits, and Evaluations

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

Nursing Home Evacuation Planning and Execution

- The HHS/OIG examined nursing home evacuation planning and executions at the request of the Senate Special Committee on Aging after the catastrophes in the gulf states precipitated by Hurricanes Katrina and Rita raised concerns about the adequacy of both nursing home evacuation plans and of the coordination efforts among facilities and State/local authorities. Nursing home residents and their families rely on nursing home management to plan for and execute appropriate evacuation procedures during times of disaster. Medicare and Medicaid regulations require that participating nursing facilities have detailed, written plans to meet all potential emergencies and disasters, and that the facilities train their employees in such plans. This study responds to the Committees request and also continues the ongoing work of OIG to monitor the health and safety of nursing home residents. The study assessed whether selected nursing homes, all located in the four gulf states affected by recent hurricanes, complied with Federal requirements to develop and practice emergency preparedness plans and whether the plans included

evacuation of residents. The report also examined the extent to which plans were executed by facilities that evacuated or considered evacuation during the recent disasters. After finding that all of the selected nursing homes experienced difficulty executing their emergency preparedness plans, the OIG recommended that CMS consider strengthening Federal certification standards for nursing home emergency plans, and consider encouraging communication and collaboration between state and local emergency entities and nursing homes. CMS concurred with both recommendations and has improvement efforts underway, including the creation of a Survey and Certification Provider Emergency Preparedness Stakeholders Group and implementation of a Survey and Certification Provider Emergency Preparedness Regulation and Guidance resource website.

Upper Payment Limit Calculations

- The HHS/OIG audited four states' upper payment limit (UPL) payments to determine whether states calculated the UPLs for hospitals and nursing facilities in a manner consistent with Federal requirements. The UPL is based on an estimate of the amount that would be paid for Medicaid services under Medicare payment principles. The HHS/OIG found that the Medicaid programs in Alabama, Indiana, Mississippi, and New York did not comply with Federal regulations governing the calculation of UPLs, and recommended that three of the four states refund a total of \$72.2 million in unallowable Medicaid payments that resulted from the states' errors. Further, the HHS/OIG recommended that two of the states, Alabama and Mississippi, work with CMS to resolve an additional \$219 million in potential Federal overpayments.

Medicaid Hospital Outlier Payments

- Some states make outlier payments to hospitals when the cost of treating a Medicaid inpatient is extraordinarily high compared with the average cost of treating comparable conditions. The HHS/OIG reported on five states' methods of computing outlier payments: New York, North Carolina, Ohio, Pennsylvania and Texas. In New York and Pennsylvania, the HHS/OIG found that although the states' outlier computation methodologies were reasonable, they relied on inaccurate or obsolete cost-to-charge ratios. In the remaining three states, the HHS/OIG found that the methodologies employed did not result in reasonable outlier payments. The HHS/OIG recommended to all five states that they prospectively address the vulnerabilities identified in the audit reports.

Medicaid Targeted Case Management Services

- The Social Security Act authorizes state Medicaid agencies to provide case management services to Medicaid beneficiaries. The Act defines case management services as services that assist a beneficiary in gaining access to needed medical, social, educational, or other services. CMS further defined such services to include assessment of service needs, development of care plans, referral to needed services, and monitoring and follow-up. The

HHS/OIG audited Massachusetts's claims for Federal matching for the cost of its Medicaid case management services. It found that the state overstated its claims by, among other things, including the cost of direct services, rather than merely case management services. The HHS/OIG recommended that the state refund approximately \$87 million to the Federal Government, and work with CMS to determine the allowability of an additional \$26.6 million (\$13.5 million Federal share) in potentially improper case management claims.

Medicaid School-Based Services. The HHS/OIG continued its focus on states' claims for school-based Medicaid services. The Medicaid program allows Medicaid reimbursement for covered health-related services in a school setting. Local education agencies (LEAs) bill the costs for these services to the states, which in turn bill them to Medicaid. The HHS/OIG conducted audits on various aspects of school-based claiming practices in New Jersey, Texas and Kansas.

- In New Jersey, the HHS/OIG found that 109 of 150 sampled school-based claims did not comply with the Federal and state requirement that eligible school children receive speech, physical, and occupational therapy services and nursing services only pursuant to a health professional's prescription. The HHS/OIG recommended that New Jersey refund to CMS the approximately \$51 million in unallowable school-based Medicaid costs.

In Texas, the HHS/OIG conducted two audits:

- In the first audit, the HHS/OIG found that 991 of 2,175 sampled claims for school-based services were unallowable for various reasons, such as missing prescriptions, claims for non-reimbursable services, missing individual education plans, failure to meet transportation requirements, and others. As a result, the HHS/OIG recommended that the state refund \$8.7 million.
- In the second review, the HHS/OIG found that a consortium of Texas LEAs claimed Medicaid school-based administrative costs that were not reasonable, allowable, or adequately supported. Such costs included unallowable personnel costs, unallowable operating costs, and overstated costs. In addition, the consortium incorrectly allocated costs and did not offset costs with revenues received from other sources. The HHS/OIG recommended that the state refund the \$2.4 million in costs that the HHS/OIG identified as unallowable.

In Kansas, the HHS/OIG conducted three audits:

- In the first audit, the HHS/OIG examined the bundled rate that the state used to both reimburse LEAs for the costs of providing school-based services and also to claim such costs from the Federal Government. The HHS/OIG found that the state misapplied the state's own methodology, which was based on the average cost of providing services over

a nine-month period (a school year). Instead, the state calculated the rate based on the cost of providing services over a full year. The HHS/OIG recommended that the state refund \$13.9 million in overpayments.

- In the second audit, the HHS/OIG sampled 300 claims for 3 school districts. Of these, 217 were unallowable because they were either for services that were not provided or for services that required a prescription, but for which there was none. The HHS/OIG recommended that the state refund the \$5.1 million in claims that were unallowable for these reasons.
- In the third audit, the HHS/OIG found that the state did not develop the payment rates for Medicaid school-based health services pursuant to Federal requirements and the state plan. The state used incorrect indirect cost rates and service utilization data to develop the payment rates. Based on these findings, the HHS/OIG recommended that the state refund \$18.5 million to the Federal Government.

Medicaid Family Planning Services. The HHS/OIG also continued its oversight of states' claims for the cost of providing Medicaid family planning services. Medicaid reimburses the costs of family planning services at an enhanced Federal matching rate of 90 percent. The HHS/OIG found that states did not always comply with Federal requirements when claiming these costs.

- In Pennsylvania, the HHS/OIG found that the state included in its methodology for calculating family planning costs services that were not reimbursable as family planning services, such as child birth delivery, as well as family planning services that were provided to ineligible beneficiaries. The HHS/OIG recommended that the state refund to the Federal Government the resulting \$15.1 million in overpayments.

Medicaid Provider Overpayments

- State Medicaid agencies are required to refund the Federal share of overpayments at the end of the 60-day period following the discovery of the overpayment. The HHS/OIG conducted reviews in Florida, New Jersey, and Montana to determine whether the states reported Medicaid overpayments in accordance with Federal requirements. The reviews found that the states did not report all overpayments and adjustments of overpayments as required. As a result, the HHS/OIG recommended that the states refund \$23.8 million to the Federal Government.

Medicaid Disproportionate Share Hospitals. States are required to make Medicaid disproportionate share hospital (DSH) payments to hospitals that serve disproportionate numbers of low-income patients with special needs.

- In a report summarizing reviews of DSH programs in 10 states (Alabama, California, Illinois, Louisiana, Missouri, North Carolina, Ohio, Texas, Virginia, and Washington), the HHS/OIG noted that 9 of the 10 states had not complied with the hospital-specific DSH limits. As a result of using historical rather than actual costs and including unallowable costs in the DSH calculations, DSH payments exceeded the hospital-specific limits by \$1.6 billion. Also, three states required hospitals to return DSH payments of \$3.6 billion to the states through intergovernmental transfers. Among other things, the HHS/OIG recommended that CMS ensure that the monetary recommendations to the states are resolved.

- DSH payments to a hospital in New Jersey exceeded the hospital-specific limits by \$171.4 million (\$85.7 million Federal share) as a result of including ineligible amounts in the DSH calculations and claiming duplicate DSH expenditures. The HHS/OIG recommended that the state refund the \$85.7 million to the Federal Government.

Drug Pricing

- In 2005, Medicare began paying for most Part B drugs using a new methodology based on average sales prices. The Act specifies the unit that manufacturers must use when submitting average sales price data. The Act also specifies the way to calculate a volume-weighted average sales price for a Medicare payment code based on manufacturer-reported average sales price data. However, CMS opted to change the unit of average sales price submission, exercising discretion permitted under the Act. It was therefore necessary for CMS to modify the method for calculating volume-weighted average sales prices described in the law. The HHS/OIG found that the method CMS currently uses to calculate a volume-weighted average sales price is mathematically incorrect. Therefore, CMS's equation may not always yield a volume-weighted average sales price that is consistent with the volume-weighted average sales price derived from the calculation set forth in the Act. Because CMS calculates volume-weighted average sales prices incorrectly, current and future reimbursement amounts may not be accurate. The HHS/OIG recommended that CMS change its calculation of volume-weighted average sales prices.

- The Act also requires that the HHS/OIG notify the Secretary if the average sales prices for a particular drug exceeds the average manufacturer price (AMP) or widely available market price by a threshold of 5 percent. If that threshold is met, the Act grants the Secretary authority to disregard the average sales prices and substitute the payment amount for the drug with the lesser of the widely available market price (if any) for the drug or 103 percent of the available market price. The HHS/OIG recently completed the following three studies that compare average sales prices to AMP and widely available market price:

Medicare Part B Drug Prices: A Comparison of Average Sales Prices to Average Manufacturer Prices. The HHS/OIG found that in the third quarter of 2004, 51 of the 364

procedure codes (14 percent) included in this review had an average sales price that exceeded the AMP by at least 5 percent. If reimbursement amounts for these 51 codes had been lowered to 103 percent of the AMP, Medicare expenditures would have been reduced by an estimated \$164 million in 2005.

Comparison of Fourth Quarter 2005 Average Sales Prices to Average Manufacturer Prices: Impact on Medicare Reimbursement for the Second Quarter of 2006. The HHS/OIG found that for 46 of the 341 procedure codes (13 percent) included in this review, average sales prices exceeded AMP by at least 5 percent in the fourth quarter of 2005. Twenty of these codes were identified in the HHS/OIG's previous report as having average sales prices that exceeded AMPs by at least 5 percent in the third quarter of 2004. If reimbursement amounts for the 46 codes had been based on 103 percent of the AMP, the HHS/OIG estimated that Medicare expenditures would have been reduced by \$64 million in 1 year.

A Comparison of Average Sales Prices to Widely Available Market Prices: Fourth Quarter 2005. For this analysis, the HHS/OIG specifically selected a purposive sample of nine procedure codes for which the HHS/OIG suspected that average sales prices might exceed widely available market prices by at least 5 percent. The purposive sample was based on the results of the September 2005 HHS/OIG report on adequacy of reimbursement for cancer drugs. The HHS/OIG found that five of the nine procedure codes included in this review met or surpassed the 5-percent threshold defined by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). For these 5 codes, the average sales prices exceeded the widely available market prices by a range of 17 to 185 percent. The HHS/OIG estimated that Medicare expenditures would be reduced by as much as \$67 million in 2006 if reimbursement amounts were lowered to the widely available market prices for these five codes.

- The Medicaid drug rebate program requires manufacturers of prescription drugs to determine and report the AMP -- generally the average prices paid to the manufacturer by wholesalers for drugs distributed to retail pharmacies. Manufacturers pay rebates to states based on AMPs and other factors. The Deficit Reduction Act (DRA) of 2005 changed the manner in which drug manufacturers determine the AMP and required that the AMP be used in setting Federal upper payment limits for certain drugs under the Medicaid program. The DRA also directed the HHS/OIG to review the requirements for determining AMPs, and to make recommendations based on this review. The HHS/OIG found that some AMP requirements were unclear and that manufacturers' methods of calculating AMPs were inconsistent. The HHS/OIG recommended that the Secretary direct CMS to clarify requirements for determining certain aspects of AMPs, consider addressing issues raised by industry groups, issue guidance that specifically addresses the implementation of the AMP-related reimbursement provisions of the DRA, and encourage states to analyze the relationship between the AMP and pharmacy acquisition costs to ensure appropriate pharmacy reimbursement.

Medicare Hospital Wage Data

- Under the acute care hospital inpatient prospective payment system, CMS adjusts the Medicare base rate paid to participating hospitals by the wage index applicable to the area in which the hospital is located. The wage indexes are based on data that hospitals include in their Medicare cost reports. The HHS/OIG conducted numerous audits during FY 2006 to determine whether hospitals complied with Medicare requirements for reporting wage data in their cost reports. The HHS/OIG found errors in the hospitals' cost reports that reduce the accuracy of future wage indexes. Such errors included the misreporting of salaries and hours, contract labor costs and hours, and pension and post-retirement benefit costs. In each case, the HHS/OIG recommended that the hospital submit revised cost reports.

Graduate Medical Education for Dental Residents

- The Medicare program makes payments to teaching hospitals to support graduate medical education (GME) programs for physicians and other practitioners. The payments, which cover both direct and indirect GME costs, are based in part on the number of full-time equivalent (FTE) residents that the hospitals train. Hospitals are permitted to count dental residents who train in non-hospital settings in the hospitals' calculations of indirect and direct GME costs. The HHS/OIG reviewed hospitals in Connecticut, Iowa, Kentucky, Massachusetts, Pennsylvania, California, Ohio, Virginia, New York, and Texas to determine whether they included the appropriate number of dental residents in their FTE counts when computing Medicare GME payments. All but two of the hospitals audited committed errors in the calculations of their FTEs, resulting in total overstatements in GME claims of approximately \$14 million. In each case, the HHS/OIG recommended that the hospital amend its cost report to return the overpayment and ensure subsequent FTE calculations are accurate.

Industry Outreach and Guidance

- Advisory Opinions. Central to the HIPAA guidance initiatives is an advisory opinion process through which parties may obtain binding legal guidance as to whether their existing or proposed health care business transactions run afoul of the Federal anti-kickback statute, the CMP laws, or the exclusion provisions. During FY 2006, the HHS/OIG, in consultation with DOJ, issued 16 advisory opinions. A total of 148 advisory opinions have been issued during the first ten years of the HCFAC program.
- Corporate Integrity Agreements. Many health care providers that enter agreements with the Government to settle potential liabilities for violations of the FCA also agree to adhere to a separate CIA. Under these agreements, the provider commits to establishing a

program or taking other specified steps to ensure its future compliance with Medicare and Medicaid rules. At the close of FY 2006, the HHS/OIG was monitoring more than 390 CIAs.

Centers for Medicare & Medicaid Services

In FY 2006, the Centers for Medicare & Medicaid Services (CMS) was allocated \$22.3 million to fund a variety of projects related to fraud, waste, and abuse in the Medicare and Medicaid programs. CMS has increased its efforts to use advanced technology to detect and prevent fraud and abuse and to ensure that CMS pays the right providers, the right amount, for the right service, on behalf of the right beneficiary. Projects include:

Medicaid/State Children's Health Insurance Plan (SCHIP) Financial Management Project:

Since FY 2004, CMS hired 100 funding specialists, including accountants and financial analysts, who have worked to improve CMS's financial oversight of the Medicaid program. The primary goal for the Medicaid funding specialists during this fiscal year was to reduce cumulative questionable reimbursement by 10 percent. Through the efforts of these specialists, CMS identified and resolved \$2.9 billion of approximately \$8 billion in cumulative questionable costs. Furthermore, an estimated \$417 million in questionable reimbursement was actually averted due to the funding specialists' preventive work with states to promote proper state Medicaid financing methods prior to implementation. The funding specialists activities have included reviews of proposed Medicaid state plan amendments that relate to reimbursement; development of financial management reviews; research regarding state Medicaid financing policy and practices; working with states to resolve A-133 audits; and, among other activities, monitoring state revenue maximization contracts.

Payment Error Rate Measurement (PERM):

PERM is the program that CMS uses to implement the Improper Payments Information Act of 2002 (IPIA), which requires HHS to measure improper payments in Medicaid and SCHIP. In order to comply with the IPIA, CMS has elected to use Federal contractors to measure Medicaid and SCHIP error rates in a subset of states every year. In FY 2006, CMS measured fee-for-service Medicaid error rates. Beginning in FY 2007, however, the PERM project will expand into testing Medicaid and SCHIP fee-for-service, managed care, and eligibility.

Administration on Aging

In FY 2006, the Administration on Aging (AoA) was allocated \$3.128 million in HCFAC funds to support community education activities designed to assist older Americans and their families to recognize and report potential errors or fraudulent situations in the Medicare and Medicaid programs. In FY 2006, these efforts included a particular focus on developing and disseminating consumer education information targeted to older Americans, with low health literacy, individuals from a variety of cultural backgrounds, persons living in rural areas, and other potentially underserved populations.

The Senior Medicare Patrol (SMP) program recruits retired professionals to educate and assist Medicare beneficiaries to detect and report health care fraud, error, and abuse in the Medicare and Medicaid programs. According to the last performance information from the Assistant Inspector General for Evaluation and Inspections, over the 12-month period ending December 31, 2006, the 57 SMP projects trained over 9,500 new senior volunteers. These volunteers perform an essential function of this program by sharing the SMP message within the senior community.

Outreach to senior consumers is a key element of the SMP program. During this period, SMP projects conducted over 9,100 media events and held almost 9,000 community education events to increase beneficiary awareness about issues related to Medicare and Medicaid integrity. During this period, over 200,000 one-on-one sessions were held between volunteers and beneficiaries. As a result of SMP outreach and education efforts, over 400,000 beneficiaries were educated, either in group or one-on-one sessions.

As a result of educating beneficiaries, the projects received over 11,800 complaints. While the SMP program staff was able to address the majority of these issues for beneficiaries, over 4,000 were referred to Medicare contractors or other responsible agencies for follow-up. Over 2,500 of these complaints resulted in money recouped to the Medicare program or another action taken by the Medicare contractor or investigative agency. In total, SMP projects documented over \$700,000 recouped to the Medicare program during this period.

While it is not possible to directly track all of the cases reported and dollars recovered through SMP community education activities, or quantify the “sentinel effect” in fraud costs avoided due to increased consumer awareness, over \$105.2 million has been reported as savings attributable to the program since its inception.

Office of the General Counsel

In FY 2006, The Office of General Counsel (OGC) was allocated \$4.778 million in HCFAC funding to supplement OGC’s efforts to support program integrity activities. OGC provides legal support consistent with the statutory authority of the HCFAC program. While a considerable portion of these funds supported OGC’s litigation activity, both administrative and judicial, OGC placed an increased focus upon program integrity review this fiscal year.

FCA and Qui Tam Actions: OGC provides support to DOJ in actions relating to Medicare or Medicaid fraud under the FCA. Among these were Tenet Healthcare Corporation, and Serono S.A., as detailed under the Accomplishments section.

Criminal Prosecutions: When requested, OGC assists the United States Attorney’s Offices (USAOs) in criminal prosecution of Medicare providers. One such case involved an investigation of a group of surgeons and the hospital that purchased their surgical practice. One doctor would be listed as the lead surgeon on one operation and as assistant on a second operation going on at

the same time, or a doctor would be shown assisting multiple surgeries that were happening at the same time. Additionally, OGC worked closely to assist Federal prosecutors in the investigation of one of the owners of a power mobility supplier. The owner entered into a criminal plea agreement and pled guilty to the violation of health care fraud provisions related to furnishing power mobility to Medicare beneficiaries.

Suspensions and Revocations: OGC assists HHS in deciding whether to suspend payments to Medicare providers and suppliers, or to revoke billing privileges when problems are discovered. For example, a licensed respiratory therapist appealed the carrier's determination that he was not qualified to enroll as a supplier because respiratory therapists are not included in the list of practitioner types that may deliver services to beneficiaries without direct physician supervision. After OGC filed CMS's brief supporting the carrier's denial, pointing out lack of Congressional authorization, and advanced the arguments at a pre-hearing conference, the individual withdrew his appeal.

Civil Monetary Penalties (CMPs): During FY 2006, OGC provided legal advice to CMS regarding the development and imposition of CMPs and defended CMS in administrative appeals and judicial litigation resulting from these cases. OGC recovered over \$4 million in CMPs in FY 2006. Among these, an Administrative Law Judge (ALJ) upheld a \$220,600 CMP which included a \$10,000 per day CMP at the immediate jeopardy level for 22 days, a denial of payment for new admissions and the termination of a facility from the Medicare program based on the facility's failure to address the aggressive and destructive behaviors of a number of its residents (some of whom had criminal records) and its failure to provide adequate supervision of these residents who menaced and threatened to kill other residents.

In addition, MMA's Part D prescription drug program has created new work for OGC in the area of CMPs. For example, OGC defended CMS's imposition of a CMP on Sav-Rx, Inc., a national provider of managed care prescription services. CMS imposed a CMP on Sav-Rx as a result of the company's conduct as a prescription drug card program sponsor.

Other Provider Enforcement: OGC represented CMS in an enforcement action involving a determination to revoke the Arkansas Department of Health Central Laboratory Clinical Laboratory Improvement Amendment certificate. The effect of this revocation was to potentially shut down the state's central lab and 94 health department clinics around the state. OGC facilitated a creative solution in an attempt to avert such a result by allowing a newly created state agency, the Arkansas Department of Health and Human Services, to become the owner and operator of the central lab and 94 clinics.

Affirmative Overpayment Litigation: OGC defends numerous lawsuits challenging CMS's overpayment determinations. For example, OGC attorneys are engaged in a project involving the collection of overpayments against 383 providers who incurred overpayments as a result of billing for the cancer drug, Lupron. The total overpayment involved is almost \$2.4 million.

Medicaid Integrity: OGC provides legal support to CMS's new Medicaid Integrity Program, established by the DRA. OGC has been working on a recent HHS/OIG audit finding that \$86.6

million in Federal financial participation has been inappropriately claimed by the Massachusetts State Medicaid agency for targeted case management services. The state agency disagreed with the audit finding, and asked CMS to reconsider the matter. OGC also received favorable decisions from the DAB in two appeals by Illinois which upheld over \$100 million in disallowances of Federal financial participation (\$98.6 million in one appeal and \$19.9 million in the other appeal) regarding Medicaid school-based services.

Other Program Integrity Activity:

Advising the Agency on the Physician Self-Referral Law and Electronic Prescribing, Electronic Health Records, and Specialty Hospitals. OGC worked closely with CMS and HHS in the drafting of a final rule aimed at one of HHS' highest priorities: encouraging adoption of electronic health information technology. CMS proposed two exceptions to the physician self-referral prohibition under which certain entities would be permitted to donate to physicians valuable electronic prescribing software, equipment, and training services on electronic health records software and training services, provided that the arrangements satisfy several criteria designed to prevent fraud and abuse.

Defending regulatory challenges in litigation. A Federal district court has dismissed for lack of standing a regulatory challenge brought by Renal Physicians Association regarding a provision in the CMS regulations that interprets a physician self-referral (Stark) safe harbor. Under the safe harbor, hourly physician compensation calculated using either of two specified methodologies is deemed to be "fair market value." The court ruled that Renal Physicians Association lacked standing to sue, and should instead petition CMS to modify or eliminate the safe harbor in the final rule.

Health Resources and Services Administration

In 2006, the Health Resources and Services Administration allocated \$450,320 in HCFAC funding to the Healthcare Integrity and Protection Data Bank (HIPDB) to supplement the overall operations and maintenance of the program. The primary focus of the HIPDB is to prevent or reduce fraud and abuse in the medical system and to enhance quality health care by serving as a repository for collecting, maintaining, and reporting on final adverse actions taken against health care providers, suppliers and practitioners. This information helps prevent practitioners, providers, and suppliers with problem backgrounds from moving from state to state unnoticed by licensing, government and health plan officials, thus improving health care quality. It also assists law enforcement officials in their efforts against health care fraud and abuse.

As a result of HCFAC funding, the following enhancement was under development in FY 2006 to improve the HIPDB system timeliness, availability and performance:

- Over the past four years, HRSA has explored the feasibility of providing a Proactive Disclosure Service (PDS) to entities' eligible to query the data banks. With this service, all eligible entities that choose to register their practitioners with the National Practitioner Data Bank (NPDB) and/or HIPDB will be notified of new reports that name any of their

registered practitioners as subjects within one day of the data banks' receipt of the report. The PDS system is scheduled to be implemented in 2007. Data bank users were invited to participate in the prototype.

The HIPDB opened for reporting on November 22, 1999. As of September 30, 2006, the HIPDB contained 255,879 reports of health care related civil judgments, criminal convictions, injunctions, licensing and certification actions, exclusions from state and Federal health care programs, and other adjudicated actions involving 147,499 individuals and 5,939 organizations.

The HIPDB opened for routine queries on March 6, 2000. By September 30, 2006, the HIPDB had responded to 6,194,850 queries from state and Federal agencies (including law enforcement) and health plans. Health plans were responsible for 78.4 percent of the queries.

The HIPDB has processed over 6.5 million queries since 2000 and maintains approximately 256,000 reports.

Office of the National Coordinator for Health Information Technology

In FY 2006, the Office of the National Coordinator for Health Information Technology (ONC) was allocated \$490,000 in HCFAC funding. This funding was used to fund an anti-fraud project. The project included the following four tasks:

- Work with Federal agencies, health information technology vendors, health care providers, private health insurers, and the National Health Information Network process to develop and coordinate model functionalities and requirements for health care anti-fraud data collection in electronic health records, and the submission, compilation and analysis of such data;
- Work with the Health Information Technology Standards Panel to identify existing and new standards needed to meet model functionalities and requirements, and develop a plan to complete the needed standards;
- Work with the Certification Commission for Health Information Technology on translating model functionalities and requirements for health care anti-fraud data collection and management into electronic health records certification criteria; and develop detailed specifications for testing the electronic health records anti-fraud certification criteria to enable ONC to pilot test the criteria.

All of the abovementioned tasks are based upon two reports issued in FY 2005 by the Foundation of Research and Education of the American Health Information Management Association which detailed how health information technology can address the growing problem of health care fraud, and demonstrated the need for additional research on anti-fraud technology and electronic health records.

FUNDING FOR THE DEPARTMENT OF JUSTICE

United States Attorneys

In FY 2006, the United States Attorney's Offices (USAOs) were allocated \$30.4 million in HCFAC funding to support civil and criminal health care fraud and abuse litigation as exemplified in the Program Accomplishments section. The USAOs dedicated substantial resources to combating health care fraud and abuse in FY 2006, and HCFAC allocations have supplemented those resources by providing funding for attorneys, paralegals, auditors and investigators, as well as funds for litigation of resource-intensive health care fraud cases.

The 93 United States Attorneys and their assistants, or AUSAs, are the nation's principal prosecutors of Federal crimes, including health care fraud, and each district has a designated Criminal Health Care Fraud Coordinator and a Civil Health Care Fraud Coordinator. Civil cases are also obtained by USAOs by means of qui tam complaints. Under the FCA, a qui tam plaintiff (a "relator") must file his or her complaint under seal in a United States District Court, and serve a copy of the complaint upon the USAO for that judicial district, as well as the Attorney General.

In addition to the positions funded by HCFAC, the Executive Office for the United States Attorneys' Office of Legal Education uses HCFAC funds to train AUSAs and other DOJ attorneys, as well as paralegals, investigators, and auditors in the investigation and prosecution of health care fraud. In FY 2006, courses and presentations on health care fraud included the Health Care Fraud Coordinator's Conference for Civil and Criminal AUSAs, Health Care Fraud for new AUSAs, and Affirmative Civil Enforcement for Auditors, Investigators and Paralegals. USAOs also handle most criminal and civil appeals at the Federal appellate level.

Criminal Prosecutions

In FY 2006, the USAOs received 836 new criminal matters involving 1,448 defendants, and had 1,677 health care fraud criminal matters pending,⁷ involving 2,713 defendants. The USAOs filed criminal charges in 355 cases involving 579 defendants, and obtained 547 federal health care related convictions.

Civil Matters

USAOs play a major role in health care fraud enforcement by bringing affirmative civil cases to recover funds that federal health care programs have paid as a result of fraud, waste, and abuse. USAOs use affirmative civil enforcement litigation to recover monies wrongfully taken from the Medicare Trust Fund and other taxpayer-funded health care systems, and to ensure that the federal health care programs are fully compensated for the losses and damages resulting from such thefts. Civil AUSAs, similar to their criminal counterparts, litigate a wide variety of health care fraud matters including false billings by doctors and other providers of medical services, overcharging

⁷When a USAO accepts a criminal referral for consideration, the office opens it as a matter pending in the district. A referral remains a pending matter until an indictment or information is filed or it is declined for prosecution.

by hospitals, Medicaid fraud, kickbacks to induce referrals of Medicare or Medicaid patients, fraud by pharmaceutical companies, and failure of care allegations against nursing home owners.

In FY 2006, USAOs opened 698 new civil health care fraud matters and filed 217 new civil health care fraud cases. At the end of FY 2006, the USAOs had 1,268 civil health care fraud matters and 748 cases pending. Civil health care fraud referrals are often made to USAOs through the law enforcement network described above, and these cases are usually handled primarily by the USAOs, though they are sometimes handled jointly with the Civil Division. The other principal source of referrals of civil cases for USAOs is through the filing of qui tam (or whistleblower) complaints. These cases are often handled jointly with trial attorneys within the Civil Division, but may be handled by the USAO itself.

Civil Division

In FY 2006, the Civil Division was allocated \$15.459 million in HCFAC funding to support civil health care fraud litigation (this amount includes \$1 million allotted for the Nursing Home and Elder Justice Initiative). Civil Division attorneys pursue civil and criminal remedies in health care fraud matters, working closely with the USAOs, the FBI, the HHS/OIG and the Department of Defense, CMS, and other federal and state law enforcement agencies. Cases involve providers of health care services, supplies and equipment, as well as carriers and fiscal intermediaries, that defraud Medicare, Medicaid, TRICARE, the Federal Employees Health Benefits Program (FEHB), and other government health care programs.

In FY 2006, the Division opened or filed a total of 239 health care fraud cases or matters. In addition to these new efforts, the Civil Division pursued 680 existing cases or matters that remained open at the end of FY 2005. Civil Division attorneys were actively involved in the recoveries described earlier in this report. In addition, the Civil Division provided in-depth, multi-day, training to AUSAs nationwide on the FCA and other civil fraud remedies, including issues relating to the investigation and litigation of qui tam cases, and continued to provide training to DOJ and HHS components on a regular basis.

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

The Civil Division continues to staff and provide a critical coordination function in the FCA investigations alleging pharmaceutical price reporting fraud against government health care programs. These matters involve hundreds of manufacturers and related entities, span multiple districts and present myriad legal and factual issues. Civil Division attorneys have spearheaded substantial efforts to share information and evidence, as appropriate, with the USAOs and other components of DOJ, as well as HHS components including the Food and Drug Administration. In addition, close communication with state Medicaid Fraud Control Units and state attorneys general is ongoing to ensure that federal and state investigations and litigation are coordinated. Since 1999, cases involving violations of the Food Drug and Cosmetic Act, or other types of fraud by pharmaceutical manufacturers in connection with Federal health benefit programs have resulted in total criminal and civil recoveries of over \$5.3 billion.

In addition to these accomplishments, the Nursing Home and Elder Justice Initiative, coordinated by the Civil Division, among other things, supports enhanced prosecution and coordination at federal, state and local levels to fight abuse, neglect, and financial exploitation of the nation's senior and infirm population. This initiative makes grants to promote prevention, detection, intervention, investigation, and prosecution of elder abuse and neglect, and to improve the scarce forensic knowledge in the field. The Civil Division is also pursuing a growing number of cases under the FCA involving providers' egregious "failures of care."

Civil Division attorneys, working with attorneys in the Criminal Division and the Executive Office of United States Attorneys (EOUSA), have played a critical role in coordinating and presenting the views of the Department of Justice to the Department of Health and Human Services as the two Departments coordinate their respective health care fraud enforcement efforts. Civil Division attorneys assisted CMS as it implemented its Medicaid Integrity Program that was created by the DRA. Civil Division attorneys also assisted in enhanced Federal Medicaid fraud enforcement efforts, providing assistance in the planning and implementation of a training conference sponsored by the HHS/OIG and held at the National Advocacy Center in September, 2006.

Criminal Division

The Criminal Division was allocated \$1.58 million in HCFAC funding to support criminal health care fraud litigation, prevention and interagency coordination in FY 2006. The Criminal Division's Fraud Section develops and implements white collar crime policy, and supports the Federal white collar crime enforcement community through litigation, coordination, policy and legislative work. The Fraud Section is responsible for handling and coordinating complex health care fraud litigation nationwide. The Fraud Section also supports the USAOs with legal and investigative guidance, training, and, in certain instances, provides trial attorneys to prosecute criminal health care fraud cases.

In FY 2006, the Fraud Section provided guidance to FBI agents, AUSAs and Criminal Division attorneys on criminal, civil and administrative tools to combat health care fraud, and worked on an interagency level through the following activities:

- coordinating large scale multi-district health care fraud investigations;
- providing frequent advice and written materials on confidentiality and disclosure issues arising in the course of investigations and legal proceedings regarding patient medical records, including HIPAA medical privacy requirements, compliance with the Substance Abuse Patient Medical Records Privacy Act and regulations, and coordinating referrals from the HHS Office of Civil Rights of possible criminal violations of the HIPAA privacy statute;
- providing training and training materials for AUSAs, investigative agents, support staff, program agency officials, and state and local law enforcement on health care fraud enforcement and medical records privacy issues;
- monitoring and coordinating DOJ responses to legislative proposals, major regulatory initiatives, and enforcement policy matters related to prevention, deterrence and punishment of health care fraud and abuse;
- reviewing and commenting on health care provider requests to the HHS/OIG for advisory opinions, and consulting with the HHS/OIG on draft advisory opinions per HIPAA requirements;
- working with USAOs and CMS to improve Medicare contractors' fraud detection, referrals to law enforcement for investigation, and case development work;
- preparing and distributing to all USAOs and FBI field offices periodic summaries of recent and significant health care fraud cases; and
- organizing, overseeing and participating on interagency working groups formed to address specific cases and initiatives, often in conjunction with the Civil Division and Executive Office for United States Attorneys.

In FY 2006, Fraud Section attorneys and the USAO from the Eastern District of Louisiana filed a superseding indictment of four corporate executives in a case involving the collapse of Louisiana's third largest health maintenance organization and its subsequent takeover and liquidation by the state Department of Insurance. The USAO for the Southern District of Florida and Fraud Section attorneys also indicted five defendants who were involved in a scheme to defraud Medicare by submitting prescriptions for groups of Medicare beneficiaries who were paid kickbacks by certain pharmacies to allow the fraudulent billing of aerosol medicines. These cases are scheduled to go to trial in 2007.

Along with the USAO for the Southern District of Mississippi, Fraud Section attorneys also prosecuted seven individuals who participated in a scheme to create bogus prescription histories and file fraudulent claims against a \$400 million settlement fund established by the manufacturer of the diet drugs Redux and Pondimin, commonly known as "Fen-Phen," for medical injuries

caused by the inappropriate prescription of these products. As of September 30, 2006, a total of 25 defendants were convicted in this multi-year ongoing joint investigation.

Fraud Section staff, along with criminal and civil AUSAs, trained CMS regional and central office staff hired to administer the Medicare prescription drug (Part D) benefit and monitor the Prescription Drug Plans and Medicare Advantage Prescription Drug Plans on Federal health care fraud statutes and possible fraud schemes which could occur in the Medicare Part D program. The team of Fraud Section staff and AUSAs also conducted two national training seminars for CMS Medicare Drug Integrity Contractor (MEDICs) staff hired to conduct program integrity and anti-fraud work for the Part D program. In collaboration with the Civil Division, the Fraud Section co-sponsored a national training and coordination seminar for AUSAs and DOJ attorneys focused on pharmaceutical fraud matters and Food, Drug, and Cosmetic Act violations.

The Fraud Section, along with the Civil Division and EOUSA, prepared and broadcast three HIPAA medical privacy rule national training seminars from the National Advocacy Center over the Justice Television Network for: all DOJ personnel who obtain and use medical records; all Federal health oversight investigators and prosecutors; and a final program for all general state and law enforcement personnel which was co-broadcast on the new National District Attorneys' Association training network. In conjunction with HIPAA medical privacy broadcast, Fraud Section staff distributed written training materials and laminated reference cards summarizing and explaining the specific HIPAA law enforcement and Federal Privacy Act exceptions that permit disclosure of personally identifiable health information in certain circumstances to criminal investigators and police to over 16,000 state and local law enforcement agencies nationwide. The Fraud Section also responded to hundreds of follow-up questions and requests from local law enforcement agencies for additional guidance on HIPAA.

Civil Rights Division

In FY 2006, the Civil Rights Division was allocated \$1.98 million in HCFAC funding to support Civil Rights Division litigation activities related to health care fraud and abuse. The Civil Rights Division pursues relief affecting public, residential health care facilities. The Division has also established an initiative to eliminate abuse and grossly substandard care in public, Medicare and Medicaid funded nursing homes and other long-term care facilities.

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

Fiscal Year 2006 Accomplishments

As part of DOJ's Institutional Health Care Abuse and Neglect Initiative, and as an enhancement to ongoing CRIPA enforcement efforts, the Special Litigation Section staff conducted preliminary reviews of conditions and services at 29 health care facilities in twelve states during Fiscal Year 2006. The task in preliminary inquiries is to determine whether there is sufficient information supporting allegations of unlawful conditions to warrant formal investigation under CRIPA. The section reviews information pertaining to areas such as abuse and neglect, medical and mental health care, use of restraints, fire and environmental safety, and placement in the most integrated setting appropriate to individual needs. Separately, in Fiscal Year 2006, the Section opened or continued formal investigations, entered remedial agreements, or monitored existing remedial agreements regarding 45 health care facilities in 23 states, the District of Columbia, and the Commonwealth of Puerto Rico.

In Fiscal Year 2006, the Section commenced investigations of two state-operated facilities for persons with mental illness and one publicly-operated nursing home. Those facilities are Connecticut Valley Hospital, in Middletown, Connecticut, Oregon State Hospital, in Salem and Portland, Oregon, and C.M. Tucker, Jr. Nursing Care Center, in Columbia, South Carolina.

The Section found that conditions and practices at two state-operated facilities and one city-operated facility for persons with mental illness, one state-operated facility for persons with developmental disabilities, and one publicly-operated nursing home, violate the residents' Federal constitutional and statutory rights. Those facilities are: Atascadero State Hospital, in Atascadero, California, Patton State Hospital, in Patton, California, St. Elizabeths Hospital, in Washington, D.C., Lanterman Developmental Center, in Pomona, California, and Fort Bayard Medical Center, in Fort Bayard, New Mexico.

The Section entered settlement agreements to resolve its investigations of one publicly-operated nursing home, two state-operated facilities for persons with developmental disabilities, and nine state-operated facilities for persons with mental illness. Those facilities are: A Holly Patterson Extended Care Facility, in Uniondale, New York; Woodbridge Developmental Center, in Woodbridge, New Jersey; the Communities at Oakwood, in Somerset, Kentucky; Vermont State Hospital, in Waterbury, Vermont; Dorothea Dix Hospital, in Raleigh, North Carolina; Broughton Hospital, in Morganton, North Carolina; Cherry Hospital, in Goldsboro, North Carolina; John Umstead Hospital, in Butler, North Carolina; Metropolitan State Hospital, in Norwalk, California; Napa State Hospital, in Napa, California; Atascadero State Hospital, in Atascadero, California; and Patton State Hospital, in Patton, California.

The Section continued its investigations of eight residential facilities for persons with developmental disabilities: Agnews Developmental Center, in San Jose, California; Sonoma Developmental Center, in Eldridge, California; Lanterman Developmental Center, in Pomona,

California; Rainier Residential Rehabilitation Center, in Buckley, Washington; Frances Haddon Morgan Center, in Lacey, Washington; Conway Developmental Center, in Conway, Arkansas; Lubbock State School, in Lubbock, Texas; and Bellefontaine Developmental Center, in St. Louis, Missouri. In addition, the Section continued its investigations of two publicly-operated nursing homes: Charlotte Hall Veterans Home, in Charlotte Hall, Maryland; and the Laguna Honda Hospital and Rehabilitation Center in San Francisco, California. The Section also continued its investigation of one residential facility for persons with mental illness: St. Elizabeths Hospital in the District of Columbia. In some of these matters, the Section is reviewing voluntary compliance to improve conditions.

The Section monitored the implementation of remedial agreements for 13 facilities for persons with developmental disabilities: Fort Wayne State Developmental Center, in Fort Wayne, Indiana; Central Wisconsin Center, in Madison, Wisconsin; Southern Wisconsin Center, in Union Grove, Wisconsin; Pinecrest Developmental Center, in Pinecrest, Louisiana; Hammond Developmental Center, in Hammond, Louisiana; Clover Bottom Developmental Center, in Nashville, Tennessee; Greene Valley Developmental Center, in Greeneville, Tennessee; Harold Jordan Center, in Nashville, Tennessee; Arlington Developmental Center, in Arlington, Tennessee; New Lisbon Developmental Center, in New Lisbon, New Jersey; Southbury Training School, in Southbury, Connecticut; Woodward Resource Center, in Woodward, Iowa; and Glenwood Resource Center, in Glenwood, Iowa. It also monitored the implementation of remedial agreements regarding community placements from facilities for persons with developmental disabilities in Indiana, Puerto Rico, and Washington, D.C.

The Section monitored the implementation of remedial agreements for four nursing homes: Banks-Jackson-Commerce Medical Center and Nursing Home, in Commerce, Georgia; Nim Henson Geriatric Center, in Jackson, Kentucky; Reginald P. White Nursing Facility, in Meridian, Mississippi; and Mercer County Geriatric Center, in Trenton, New Jersey. The Section also monitored the implementation of a remedial agreement regarding two state-operated residential facilities for persons with mental illness: Hawaii State Hospital in Kanehoe, Hawaii (and the associated community mental health system) and Memphis Mental Health Institute, in Memphis, Tennessee. Finally, the Section monitored the implementation of a remedial agreement regarding one residential facility for children with visual disabilities: New Mexico School for the Visually Handicapped, in Alamogordo, New Mexico.

Page intentionally left blank

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 ©, to be available without further appropriation - (I) for fiscal year 2006, \$114,100,000.”

In FY 2006, the FBI was allocated \$114 million in HCFAC funding for health care fraud enforcement. This yearly appropriation was used to support 775 positions (455 Agent, 320 Support) in FY 2006, a decrease of 31 positions from the positions supported in FY 2005 (11 Agent, 20 Support). The FY 2006 funding did not allow for cost of living increases, necessitating reductions in funded staffing levels. The number of pending investigations has shown steady increase from 591 cases in 1992 to 2,423 cases through 2006. FBI-led investigations resulted in 535 criminal health care fraud convictions and 588 indictments and informations being filed in FY 2006.

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

Health care fraud investigations are considered a priority within the White Collar Crime Program Plan. In addition to being a partner in the majority of investigations listed in the body of this report, FBI field offices throughout the U.S. have proactively addressed significant health care fraud through coordinated initiatives, task forces, and undercover operations to identify and pursue investigations against the most egregious offenders which may include organized criminal activity and criminal enterprises. Organized criminal activity has been identified in the operation of medical clinics, independent diagnostic testing facilities, DME companies and other health care

facilities. The FBI is committed to addressing this criminal activity through disruption, dismantlement and prosecution of criminal organizations.

The FBI initiated the Internet Pharmacy Fraud Initiative which focuses on Internet web sites and individuals selling illegal prescription drugs and controlled substances. The overall goal of the Internet Pharmacy Fraud Initiative is to identify fraudulent Internet pharmacies and target physicians who are willing to write prescriptions for financial gain outside of the doctor/patient relationship and with no legitimate medical purpose. Also in the scope of this initiative are investigations involving the sale of counterfeit and diverted pharmaceuticals on the Internet.

The majority of funding received by the FBI is used to pay personnel costs associated with the 775 funded positions. Funds not used directly for personnel matters are used to provide operational support for major health care fraud investigations and national initiatives currently focusing on pharmaceutical fraud and outpatient surgery centers. Further, the FBI continues to support individual investigative needs such as the purchase of specialized equipment and expert witness testimony on an as-needed basis.

Glossary Of Terms

The Account - The Health Care Fraud and Abuse Control Account

AHM - American Healthcare Management Inc.

AIDS - Auto-Immune Deficiency Syndrome

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

AMP - Average Manufacturer Prices

AUSA - Assistant United States Attorney

BIA - Bioelectrical Impedance Analysis

CIA - Corporate Integrity Agreement

CMN - Certificate of Medical Necessity

CMP - Civil Monetary Penalty

CMPL - Civil Monetary Penalties Law, 42 U.S.C. § 1320a-7a

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

CRIPA - Civil Rights of Institutionalized Persons Act

DME - Durable Medical Equipment

DRA - Deficit Reduction Act of 2005

DOJ - The Department of Justice

DSH - Disproportionate Share Hospital

EOUSA - Executive Office for the United States Attorneys

FBI - Federal Bureau of Investigation

FCA - False Claims Act

FDA - Food and Drug Administration

FEHBP - Federal Employees Health Benefits Program

FTE-Full-time equivalent

GHP - Group Health Plan

GME - Graduate Medical Education

GPO - Group Purchasing Organization

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

HHS - The Department of Health and Human Services

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

HI - Hospital Insurance Trust Fund

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

HIPDB - Healthcare Integrity and Protection Data Bank

HIV - Human Immunodeficiency Virus

HMO - Health Maintenance Organization

HRSA - The Department of Health and Human Services - Health Resources and Services Administration

LEA - Local Education Agencies

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

MSP - Medicare Secondary Payer

NAMFCU - The National Association of Medical Fraud Control Units

NHCAA - National Health Care Anti-Fraud Association

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

ONC - The Department of Health and Human Services - Office of the National Coordinator for Health Information Technology

PERM - Program Error Rate Measurement

Proactive Disclosure Service - PDS

The Program - The Health Care Fraud and Abuse Control Program

SCHIP - State Children's Health Insurance Plan

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

SMP - Senior Medicare Patrol

UPL - Upper Payment Limit

USAO - United States Attorney's Office

VFC - Vaccines for Children Program