
**The Department of Health and Human Services
and
The Department of Justice
Health Care Fraud and Abuse Control Program
Annual Report for Fiscal Year 2009**

May 2010

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	32
Centers for Medicare & Medicaid Services	45
Administration on Aging	52
Office of the General Counsel	53
Department of Justice	
United States Attorneys	57
Civil Division	58
Criminal Division	59
Civil Rights Division	62
Appendix: Federal Bureau of Investigation - Mandatory Funding	66
Glossary of Terms	68

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 Inspector General, designed to coordinate Federal, state and local law enforcement activities with respect to health care fraud and abuse. In its thirteenth 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 Fiscal Year (FY) 2009, the Federal Government won or negotiated approximately \$1.63 billion in judgments and settlements², and it attained additional administrative impositions in health care fraud cases and proceedings. The Medicare Trust Fund received transfers of approximately \$2.51 billion during this period as a result of these efforts, as well as those of preceding years, in addition to over \$441 million in Federal Medicaid money similarly transferred separately to the Treasury as a result of these efforts. The HCFAC account has returned over \$15.6 billion to the Medicare Trust Fund since the inception of the Program in 1997.

Enforcement Actions

In FY 2009, U.S. Attorneys' Offices opened 1,014 new criminal health care fraud investigations involving 1,786 potential defendants. Federal prosecutors had 1,621 health care fraud criminal investigations pending, involving 2,706 potential defendants, and filed criminal charges in 481 cases involving 803 defendants. A total of 583 defendants were convicted for health care fraud-related crimes during the year. Also in FY 2009, the Department of Justice (DOJ) opened 886 new civil health care fraud investigations and had 1,155 civil health care fraud matters pending.

¹Hereafter, referred to as the Secretary.

²The amount reported as won or negotiated only reflects Federal recoveries and therefore does not reflect state Medicaid monies recovered as part of any global, Federal-State settlements. Measures have been put into place to track such related state Medicaid recoveries.

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 2009

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.

As was the case before HIPAA, amounts paid to Medicare in restitution or for compensatory damages must be deposited in the Trust Fund. The Act requires that an amount equaling recoveries from health care investigations -- including criminal fines, forfeitures, civil settlements and judgments, and administrative penalties -- also be deposited in the Medicare Trust Fund.³ 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' Office of Inspector General (OIG), with respect to Medicare and Medicaid programs. In FY 2006, the Tax Relief and Health Care Act or TRHCA (P.L. 109-432, §303) amended the Act so that funds allotted from the Account are 'available until expended'. TRHCA also allowed for yearly increases to the Account based on the change in the consumer price index for all urban consumers (all items; United States city average) or CPI-U over the previous fiscal year for fiscal years for 2007 through 2010⁴. In FY 2009, the Secretary and the Attorney General certified \$266,425,206 in mandatory funding for appropriation to the Account. Additionally, Congress appropriated \$198 million in

³Also known as the Hospital Insurance (HI) Trust Fund. All further references to the Medicare Trust Fund refer to the HI Trust Fund.

⁴The CPI-U adjustment in TRHCA did not apply to the Medicare Integrity Program (MIP).

discretionary funding. A detailed breakdown of the allocation of these funds is set forth later in this report. HCFAC appropriations generally supplement the direct appropriations of HHS and DOJ that are devoted to health care fraud enforcement and funded approximately two-thirds of the HHS/OIG's appropriated budget in FY 2009. (Separately, the Federal Bureau of Investigation (FBI) received \$126.3 million from HIPAA which is discussed in the Appendix.)

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

- (1) to coordinate Federal, state and local law enforcement efforts relating to health care fraud and abuse 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 2009, \$2.576 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/deposits⁴:

Total Transfers/Deposits by Recipient FY 2009	
Department of the Treasury	
Deposits to the Medicare Trust Fund, as required by HIPAA	
Gifts and Bequests	\$46,271
Amount Equal to Criminal Fines	\$620,965,124
Civil Monetary Penalties	\$16,582,250
Asset Forfeiture *	-
Penalties and Multiple Damages	\$482,270,136
Subtotal	\$1,119,863,780
Other Restitution to the Trust Fund	
HHS/OIG Audit Disallowances - Recovered	\$360,166,522
Restitution/Compensatory Damages	\$1,031,092,953
Subtotal	\$1,391,259,475
Grand Total of Amounts Transferred to the Medicare Trust Fund	\$2,511,123,255
Restitution/Compensatory Damages to Federal Agencies	
TRICARE	\$11,317,687
Veteran's Administration	\$22,860,564
HHS/OIG Cost of Audits, Investigations and Compliance Monitoring	\$5,385,925
Office of Personnel Management	\$4,762,253
Other Agencies	(\$27,650,230)
Subtotal	\$16,676,200
Relators' Payments**	\$48,323,034
TOTAL ***	\$2,576,122,489

*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.

⁴ The figures below do not include returns of the Federal share of Medicaid funds. In FY 2009, over \$441 million in Federal Medicaid money was transferred separately to the Treasury as result of HCFAC-related efforts. [NOTE: This figure will match the figure on page 1 of the report.]

**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; 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 thirteenth year of operation, the Secretary and the Attorney General certified \$266.4 million in mandatory funding as necessary for the Program. Additionally, Congress appropriated \$198 million in discretionary funding. The following chart gives the allocation by recipient:

FY 2009 ALLOCATION OF HCFAC APPROPRIATION⁵ (Dollars in millions)			
Organization	Mandatory Allocation	Discretionary Allocation	Total Allocation
Department of Health and Human Services			
Office of Inspector General ⁶	\$177.205	\$18.967	\$196.172
Office of the General Counsel	5.714	0	5.714
Administration on Aging	3.200	0	3.200
Centers for Medicare & Medicaid Services (CMS)	24.979	160.066	185.045
Subtotal	\$211.097	\$179.033	\$390.130
Department of Justice			
United States Attorneys	\$33.800	\$9.023	\$42.823
Civil Division	\$15.069	\$8.237	\$23.306
Criminal Division	\$3.780	\$1.606	\$5.386
Civil Rights Division	\$2.376	\$0.100	\$2.476
Nursing Home and Elder Justice Initiative	\$1.000	\$0	\$1.000
Subtotal	\$56.025⁷	\$18.966	\$74.991
TOTAL	\$267.122	\$197.999	\$465.121

⁵In FY 2007, funds became available until expended.

⁶In addition, HHS/OIG obligated \$5.8 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).

⁷ This amount includes \$600,000 from prior year carry-forward which was allocated in FY 2008. As a result, the total allocation is \$600,000 higher than the mandatory amount certified by the Secretary and the Attorney General.

ACCOMPLISHMENTS

Overall Recoveries

During this fiscal year, the Federal government won or negotiated approximately \$1.63 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 \$2.51 billion during this period as a result of these efforts, as well as those of preceding years, in addition to over \$441 million in Federal Medicaid money similarly transferred to the Treasury separately as a result of these efforts⁷.

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 fraud⁸.

Departmental Collaboration

Health Care Fraud Prevention & Enforcement Action Team (HEAT)

The Attorney General and the HHS Secretary maintain regular consultation at both senior and staff levels to facilitate, coordinate and accomplish the goals of the HCFAC Program. On May 20, 2009, Attorney General Holder and Secretary Sebelius announced the Health Care Fraud Prevention & Enforcement Action Team (HEAT), a new effort with increased tools and resources, and a sustained focus by senior level leadership to enhance the collaboration levels between the Departments of Health and Human Services and Justice. With the creation of the new HEAT effort, DOJ and HHS enhanced our commitment to fighting Medicare Fraud as a Cabinet-level priority for both DOJ and HHS. HEAT, which is jointly led by the Deputy Attorney General and HHS Deputy Secretary, is comprised of top level law enforcement agents, prosecutors and staff from DOJ and HHS and their operating divisions, and is dedicated to joint efforts across Government to both prevent fraud and enforce current anti-fraud laws around the country.

The mission of HEAT is:

- **To marshal significant resources across Government to prevent waste, fraud and abuse in the Medicare and Medicaid programs** and crack down on the fraud perpetrators who are abusing the system and costing us all billions of dollars.
- **To reduce skyrocketing health care costs and improve the quality of care by ridding**

⁷ Note that some of the judgments, settlements, and administrative actions that occurred in FY 2009 will result in transfers in future years, just as some of the transfers in FY 2009 are attributable to actions from prior years.

⁸ HHS collected approximately \$360 million in HHS/OIG recommended recoveries which are included in the total \$2.5 billion transferred to the Trust Fund in FY 2009.

the system of perpetrators who are preying on Medicare and Medicaid beneficiaries.

- **To highlight best practices by providers and public sector employees** who are dedicated to ending waste, fraud and abuse in Medicare.
- **To build upon existing partnerships that already exist between DOJ and HHS like our Medicare Fraud Strike Forces** to reduce fraud and recover taxpayer dollars.

Another key HEAT objective is to improve and expand information and data sharing procedures between HHS and DOJ so that law enforcement has access to critical data and information on a near “real-time” basis in order to identify patterns of fraud and abuse more rapidly, increase efficiency in investigating and prosecuting complex health care fraud cases, and turn off funding and profits to those who may be defrauding the system.

To achieve the mission and objectives of HEAT, the Attorney General and HHS Secretary instigated several HEAT initiatives. Significantly, the Medicare Fraud Strike Force expanded to Detroit and Houston bringing the total number of cities with Strike Force prosecution teams up to four. The HHS Office of Inspector General (HHS/OIG) implemented cutting-edge electronic discovery tools to maximize investigative efficiency in the processing and review of voluminous electronic evidence obtained during the course of our health care fraud investigations. The Centers for Medicare and Medicaid Services (CMS) launched several projects designed to improve the Durable Medical Equipment (DME) provider enrollment process, Medicare Parts C & D compliance and enforcement activities, and compliance training for providers to prevent honest mistakes and help stop potential fraud before it happens. Finally, the CMS Medicaid provider audit program expanded to help state Medicaid officials conduct audits, monitor activities and detect fraud.

In addition to the activities of HEAT, CMS and law enforcement agency representatives, such as members of the Civil and Criminal Divisions, the United States Attorneys’ Offices (USAOs) and Executive Office for the United States Attorneys (EOUSA), the Federal Bureau of Investigation (FBI), and HHS/OIG, meet on a periodic basis through numerous local or regional health care fraud working groups and task forces.

EOUSA and CMS also sponsor a monthly national conference call during which Assistant United States Attorneys from all districts have the opportunity to interact directly with CMS representatives, receive timely reports on CMS operations, and obtain answers to questions related to specific issues regarding current investigations. The Departments also convene interagency staff-level working groups as needed to develop mutual proposals for improving our health care fraud fighting capabilities.

Each Department routinely enlists senior staff from the other to participate in staff training programs, thereby encouraging the free-flow of shared expertise and accessibility. The Department of Justice's Criminal Division and HHS/OIG initiated a special program in 2007, which provides an opportunity for HHS/OIG counsel to serve six month details to gain experience

managing criminal health care fraud investigations and trial experience in Federal court with Criminal Division colleagues. That program continues. In addition, attorneys from HHS/OIG have been detailed to US Attorneys' Offices as Special Assistant U.S. Attorneys to provide USAOs with additional prosecutorial resources.

During FY 2009, the many significant HCFAC Program accomplishments included the following:

HEAT Medicare Fraud Strike Force

The Medicare Fraud Strike Force (Strike Force) was launched in March 2007 as part of the South Florida Initiative, a joint investigative and prosecutorial effort against health care fraud in South Florida. The Strike Force builds upon earlier phases of the multiagency and multidisciplinary initiatives to combat Medicare fraud and abuse among durable medical equipment (DME) suppliers and HIV infusion therapy providers. The Strike Force analyzes Medicare data to identify unexplained high-billing levels in concentrated areas so that interagency teams can target emerging or migrating schemes along with chronic fraud by criminals masquerading as health care providers or suppliers. Based on the success of these efforts, DOJ and HHS expanded the Strike Force to include teams of investigators and prosecutors in a total of four cities -- Miami, FL; Los Angeles, CA; Detroit, MI; and Houston, TX -- in FY 2009. The Departments are continuing to expand the Strike Force to additional cities where Medicare claims data reveal aberrant billing patterns and intelligence data suggest that fraud may be occurring.

Each Medicare Strike Force combines data analysis capabilities of CMS and the investigative resources of the FBI and the HHS/OIG with the prosecutorial resources of the DOJ Criminal Division, Fraud Section and the U.S. Attorneys' Offices. Strike Force accomplishments from cases prosecuted in all four cities during FY 2009 follow⁸:

- 82 cases indicted involving charges filed against 209 defendants who collectively billed the Medicare program more than \$ 253 million
- 94 guilty pleas negotiated and five jury trials litigated, winning guilty verdicts against ten defendants⁹
- Imprisonment for 77 defendants sentenced during the fiscal year, averaging more than 52 months of incarceration, and a 60-month probation sentence for one other defendant.

⁸ The accomplishments figures presented in the bullets include all reported Strike Force cases handled by DOJ Criminal Division attorneys and Assistant United States Attorneys in the respective U.S. Attorneys' Offices during FY 2009. During the previous fiscal year, the U.S. Attorneys' Offices in the Southern District of Florida and Central District of California implemented the Strike Force model for criminal health care fraud prosecutions, however, Strike Force prosecution statistics from the previous year included only cases handled with DOJ Criminal Division attorneys because more complete reporting procedures were not in place at that time.

⁹ Figures for guilty pleas and imprisonment sentences include defendants who may have been charged in Strike Force cases filed the previous year but whose plea negotiations or sentences occurred in FY 2009.

- In the two and a half years since its inception, Strike Force prosecutors filed 244 cases charging 456 defendants who collectively billed the Medicare program more than \$900 million dollars; 230 defendants pleaded guilty and 22 others were convicted in jury trials; and 188 defendants were sentenced to imprisonment for an average term of 46 months.¹⁰ Examples of successful cases initiated or concluded in each of the four districts where Strike Force prosecution teams were operational during FY 2009 follow.

Phase 1: Miami, FL

As previously noted, strike force operations were first launched in Miami, Florida in March 2007. In FY 2009, the DOJ Criminal Division and United States Attorney's Office for the Southern District of Florida continued to convict defendants of defrauding government health care programs. Notable operations include:

- In Florida, after a two-week criminal trial, a Miami jury convicted a physician and the court sentenced her to serve 30 years in prison for her role in an \$11.0 million HIV infusion fraud scheme. The physician, with the assistance of a nurse who also was convicted and sentenced to seven years in prison, ordered and then provided hundreds of unnecessary HIV infusion treatments to patients of one Miami infusion clinic who were paid cash kickbacks of \$150 per visit to accept the services so that co-conspirators could steal from Medicare. This case was part of a large-scale HIV infusion fraud operation throughout South Florida involving at least 11 clinics in schemes that totaled more than \$100.0 million in false claims to Medicare. In total, 14 co-conspirators have been convicted for their roles in these schemes, including four other physicians and a physician's assistant who was sentenced to prison for 14 years for training the physicians who worked at the clinics on how to ensure that medical records appeared to support the treatments being billed to Medicare. The co-conspirators who are the alleged masterminds of this large-scale HIV infusion fraud operation are under indictment for Medicare fraud but remain at large.
- In Florida, the owner of a Miami clinic and two co-conspirators were sentenced to prison terms of 57 months, 87 months, and 27 months, respectively. The owner was also ordered to pay \$43,000 in forfeiture. The owner admitted that from May 2003 through January 2004 she conspired with others to defraud the Medicare program of \$14 million by causing the clinic to submit fraudulent claims for HIV services that were medically unnecessary or never provided. The two co-defendants pleaded guilty to charges of conspiracy to launder the improper Medicare payments.
- In Florida, the medical director of two HIV clinics was sentenced to 84 months in prison and ordered to pay \$9.9 million in joint and several restitution in connection with a scheme to bill Medicare for medically unnecessary infusion services. The medical director admitted to conspiring with others to operate the clinics, the sole purpose of which was to

¹⁰ These statistics are for the period of May 7, 2007 through September 30, 2009.

commit Medicare fraud. He also admitted to conspiring with others to pay cash kickbacks to the Medicare beneficiaries who visited the clinics.

- In Florida, following their convictions after a two-week criminal trial, a Miami physician and a physician's assistant were each sentenced to 97 months in prison, and a second physician's assistant was sentenced to 63 months in prison, for their roles in fraud schemes that billed Medicare for \$10.9 million worth of unnecessary HIV infusion fraud treatments. The infusion clinic in this case was established for the sole purpose of defrauding Medicare – the doctors saw no true patients, administered no legitimate medical services, and paid cash kickbacks of up to \$200 per individual for each visit. Testimony also established that defendants had an arrangement with a pharmaceutical wholesale company to buy invoices showing the purchase of large amounts of medications when only minor amounts were actually bought. Another witness testified how the fraudulent clinic manipulated blood samples so that lab results would appear to support the fraudulent claims.
- In Florida, seven Miami-area residents were sentenced to prison terms ranging from 97 to 37 months and ordered to pay restitution amounts ranging from \$747,433 to \$12.5 million for a total of \$19.8 million in connection with a Medicare fraud scheme involving HIV infusion services. The seven defendants pleaded guilty to conspiracy to commit health care fraud. All seven co-conspirators worked at a Miami clinic that purportedly provided injection and infusion treatments to patients with HIV. Most of the services allegedly provided to patients at the clinic were billed to the Medicare program as treatments for a diagnosis of thrombocytopenia, a disorder involving a low count of platelets in the blood. None of the patients actually had low blood platelet counts.
- In Florida, the owner and operator of a DME company was sentenced to 54 months' incarceration and ordered to pay \$807,000 in restitution pursuant to his guilty plea to health care fraud and aggravated identity theft. The owner admitted that beginning in January 2004, he fraudulently billed Medicare for DME which were not delivered, were not prescribed by the physicians listed on the claims, or were not medically necessary. In addition, the owner acknowledged that he knowingly and willfully stole the identity of a Medicare beneficiary for the purpose of submitting false claims.
- In Florida, eight Miami-area residents were charged with conspiracy to commit health care fraud and other crimes in connection with an alleged \$22 million Medicare fraud scheme operated out of Miami businesses purporting to specialize in home health care services. The defendants recruited beneficiaries and paid kickbacks and bribes to arrange for their Medicare billing numbers to be used by their co-conspirators who operated two fraudulent home health agencies to file claims with Medicare for purported home health care services that were not provided and were not medically necessary. Defendants also falsified medical tests and records to make it appear that the services were needed. Each of the eight defendants has pleaded guilty and is awaiting sentencing.

Phase 2: Los Angeles, CA

In March 2008, the HEAT Strike Force rolled out its second phase in Los Angeles, California. Significant convictions during FY 2009 include:

- In California, an owner and operator of a Los Angeles-area durable medical equipment company pleaded guilty to charges of aggravated identity theft and health care fraud and was sentenced to 54 months in prison and ordered to pay \$807,000 in restitution. He admitted submitting false claims for orthotic braces, power wheelchairs, and other DME that were not delivered to Medicare beneficiaries, were not prescribed by the physicians listed on the claims that he made or were not medically necessary. He also acknowledged stealing the identity of a Medicare beneficiary and billed Medicare for a back brace and two knee braces that the beneficiary did not need or receive, and of which the patient had no knowledge.
- A Federal jury in Los Angeles, following a seven-day trial, convicted a physician's assistant on all counts charged in an indictment for his role in a \$7.7 million Medicare fraud scheme. According to evidence presented at trial, the defendant worked as a licensed physician assistant at a Los Angeles clinic allegedly under the supervision of a doctor. The defendant prescribed hundreds of motorized wheelchairs and custom-fitted orthotics, and ordered diagnostic tests for Medicare beneficiaries purportedly under the authority and supervision of a doctor. The doctor, whose unique physician identification number had been used by the defendant to forge medically unnecessary prescriptions, testified at trial that he never worked at the clinic nor authorized the defendant to use his physician identification number to support the claims submitted using his billing number.
- In California, after a one-week trial, a Los Angeles jury convicted the owners and operators of an area DME company for submitting almost \$1.0 million in fraudulent Medicare billings for medically unnecessary power wheelchairs and wheelchair accessories. At trial, elderly Medicare beneficiaries testified about how they were recruited and taken to Los Angeles-area medical clinics. The beneficiaries were promised vitamins, diabetic shoes, and other items that they never received in exchange for their Medicare numbers and other personal identifying information. Instead, the clinics used the Medicare beneficiary information to generate fraudulent power wheelchair prescriptions that could be sold to DME company owners who billed Medicare for the wheelchairs. Many beneficiaries did not know they would get a power wheelchair, and all of them testified at trial that they did not need or use the wheelchair. The court sentenced both defendants to serve 24 month prison terms to be followed by 36 months of supervised release, and ordered them to pay \$400,000 in restitution to the Medicare program which equals the amount of fraudulent billings paid by Medicare in the scheme.

Phase 3: Detroit, MI

In June 2009, the Strike Force expanded to Detroit, Michigan. On June 24, 2009, the DOJ

Criminal Division and United States Attorney's Office for the Eastern District of Michigan announced seven indictments charging 53 people with submitting more than \$50.0 million in false billings to Medicare in schemes involving physical and occupational therapy, and infusion/injection treatments in the third phase of the Medicare Fraud Strike Force.

- In one case it is alleged that defendants brought their fraud schemes from Miami to Detroit and billed Medicare for more than \$2.4 million in fraudulent claims. It is this very type of cross-regional spread that the expansion of Strike Force operations is designed to combat. The defendants allegedly created a healthcare company, submitted paperwork to obtain required Medicare provider numbers, hired recruiters and gave them cash to recruit patients to participate in the scheme. It is further alleged that they hired staff, such as medical billers and assistants, to give the appearance of legitimacy, and then paid the patients cash kickbacks to sign forms saying they had received treatments that were medically unnecessary and, oftentimes, were not provided. To date, six defendants have pleaded guilty to conspiracy to commit health care fraud; one defendant has been sentenced to serve a 63 month prison term, and the others are awaiting sentencing. The four remaining defendants await trial.
- Sixteen defendants were charged with conspiracy to commit health care fraud, health care fraud, and other offenses which are alleged to have totaled \$21.0 million in fraudulent billings to Medicare. Three defendants allegedly controlled operations of several fraudulent rehabilitation agencies and conspired with a physician, licensed and unlicensed therapists, and beneficiaries to fabricate claims for physical and occupational therapy, speech pathology services, and home health care visits that were medically unnecessary and were not provided. Defendants fabricated supporting medical and billing documents which falsely stated that patients had received specific therapeutic treatments when, in fact, they had not. To date, eleven defendants have pleaded guilty to these crimes, including a licensed physical therapist who was sentenced to a 37 month prison term and three beneficiaries who received probationary terms and community confinement for up to six months; the other defendants await sentencing. A jury recently convicted the doctor who participated in this scheme following a three week trial, and he awaits sentencing.

Phase 4: Houston, TX

On July 29, 2009, the Criminal Division and the United States Attorney's Office for the Southern District of Texas initiated phase 4 of the Strike Force when they announced that 32 people were indicted in Houston for schemes to submit more than \$16.0 million in false Medicare claims for durable medical equipment. The primary fraud schemes in Houston involve false billing for "arthritis kits", which were comprised of a number of orthotic devices, including braces for both sides of the body and related accessories, such as heat pads, power wheelchairs, and enteral feeding supplies.

- In Texas, an owner and operator of a DME company in Houston was indicted along with three codefendants for allegedly conspiring to submit approximately \$4.3 million in false

claims to Medicare for orthotic devices termed "arthritis kits" purportedly provided to Medicare beneficiaries who did not need or use the equipment. The indictment alleges that on 34 occasions the DME owner billed Medicare for DME items purportedly provided to 10 deceased beneficiaries. To date, one defendant has pleaded guilty in this case and the other three codefendants await trial.

- Two Texas residents and a New York resident were owners and operators of a company used to submit \$3.1 million in false Medicare claims for DME that was medically unnecessary or was not provided to Medicare beneficiaries. The three defendants paid kickbacks to a fourth member of the conspiracy in exchange for the referral of Medicare beneficiaries whose identifying information was used in order to file medically unnecessary DME claims to Medicare, including power wheelchairs, wheelchair accessories and motorized scooters. Certain Medicare beneficiaries for whom the claims were submitted either received no wheelchair or received a less expensive motorized scooter instead. Medicare beneficiaries who actually received a power wheelchair and wheelchair accessories did not need them. All four defendants in this case await trial.

Fraud by Pharmaceutical Manufacturers

- Pfizer, Inc., (Pfizer) agreed to pay \$2.3 billion, the largest health care fraud settlement in the history of the Department of Justice and HHS/OIG, to resolve criminal and civil liability arising from the illegal promotion of certain pharmaceutical products. Pfizer's subsidiary, Pharmacia and Upjohn Company, Inc., agreed to plead guilty to illegally promoting the sale of its anti-inflammatory drug, Bextra, for off-label uses and paid a criminal fine of \$1.195 billion and forfeited \$105 million, for a total criminal resolution of \$1.3 billion. In addition, Pfizer agreed to pay \$1 billion to resolve allegations in a number of qui tam cases that it illegally promoted four drugs – Bextra; Geodon, an anti-psychotic drug; Zyvox, an antibiotic; and Lyrica, an anti-epileptic drug – and caused false claims to be submitted to Government health care programs for uses that were not medically accepted indications and therefore not covered by those programs. The civil settlement also resolved allegations that Pfizer paid kickbacks to health care providers to induce them to prescribe these, as well as other, drugs. The Federal share of the civil settlement was \$668.5 million and the state Medicaid share of the civil settlement was \$331.5 million. These proceeds were collected in FY2010 and will be reported in the FY 2010 annual report. Pfizer also entered into a 5-year Corporate Interagency Agreement (CIA) with HHS/OIG.
- Eli Lilly and Company (Lilly) entered an approximately \$1.4 billion global criminal, civil, and administrative settlement to resolve allegations that it illegally marketed its antipsychotic drug Zyprexa. Under the civil settlement agreement, Lilly agreed to pay the Federal Government \$438.2 million and participating States up to \$361.8 million to resolve False Claims Act (FCA) allegations that it marketed Zyprexa for certain unapproved uses and caused false claims for payment to be submitted to Federal health care programs, such as Medicaid, from September 1999 to the end of 2005. Lilly will also

pay a criminal fine of \$515.0 million and forfeit assets of \$100.0 million. In its plea agreement, Lilly admitted that from September 1999 to March 31, 2001 it promoted Zyprexa for unapproved uses in elderly populations as treatment for dementia, including Alzheimer's dementia. Lilly also entered a 5-year CIA which provides for increased accountability by Lilly's board of directors and management in the form of an annual resolution by a board committee and annual certifications from managers about compliance.

- Bayer HealthCare, LLC (Bayer) agreed to pay \$97.5 million plus interest to settle allegations that it paid kickbacks to several DME mail order suppliers and diabetic supply distributors to induce them to provide Bayer diabetic supplies to Medicare beneficiaries. The Federal Government alleged that this conduct caused the suppliers and distributors to submit false claims to Medicare from January 1998 to December 2007. Bayer also executed a 5-year CIA in connection with the settlement. The CIA, which also applies to Bayer affiliates, includes requirements for increased accountability by Bayer's board of directors in the form of an annual resolution by the board and annual certifications from managers regarding compliance.
- Abbott Laboratories Inc., (Abbott) an Illinois-based pharmaceutical company, agreed to pay the State of Texas and the Federal Government a total of \$28.0 million in a Medicaid fraud settlement to resolve its civil liabilities related to the false pricing of certain intravenous drugs and blood products. Under Texas law, drug manufacturers participating in Medicaid are required to report their wholesale and other prices to the Medicaid program. These prices are the basis on which the Texas Medicaid program calculates reimbursement to Medicaid providers. The Federal Government alleged that Abbott falsified price reports and inflated its prices for products that it submitted to the Texas Medicaid program. As a result of the alleged illegal pricing, Texas Medicaid allegedly overreimbursed providers for Abbott's drugs.
- Tennessee-based Kindred Healthcare, Inc., (Kindred) and its successor PharMerica Healthcare Pharmacy, LLC, agreed to pay \$1.3 million to settle allegations in a *qui tam* complaint that Kindred billed Medicaid for a higher number of drugs than were actually administered. In some cases, the overbilling was for multiple times the proper amount.
- Aventis Pharmaceutical, Inc. ("Aventis"), a wholly-owned subsidiary of Sanofi-Aventis U.S., paid \$95.5 million to resolve False Claims Act allegations that, from 1995 through 2000, it gave certain HMOs secret discounts by entering into "private label" agreements for three drugs and excluded the prices offered under those agreements from the best prices Aventis reported to the Centers for Medicare and Medicaid Services.
- Endoscopic Technologies Inc. (Estech), a medical device manufacturer, paid \$1.4 million to resolve civil *qui tam* allegations that it marketed its surgical ablation devices to treat atrial fibrillation (the most common cardiac arrhythmia or abnormal heart rhythm), a use

that is not approved by the FDA. The government also alleged that Estech promoted expensive heart surgeries using the company's devices when less invasive alternatives were appropriate, advised hospitals to up-code surgical procedures using the company's devices to inflate Medicare reimbursements, and paid kickbacks to healthcare providers to use its devices.

Fraud by Physicians

- In Mississippi, a Brookhaven psychologist was sentenced to 73 months in prison and ordered to pay \$545,280 in restitution for defrauding Medicare. The defendant conspired with others to submit false and misleading patient diagnosis to the Social Security Administration in order to assist many of his patients obtain disability benefits. Once a patient was approved for disability benefits, the defendant then routinely billed Medicare, claiming that he was providing psychological health care services to patients on a weekly or semi-weekly basis, when in fact, he was treating these patients only a few times a year, if at all. As part of the scheme, the defendant and his accomplices would create false patient documentation in order to substantiate the false bills.
- In California, the former CEO of InterMune, Inc. was convicted of wire fraud for the creation and dissemination of false and misleading information about the efficacy of InterMune's Actimmune (Interferon gamma-1b) as a treatment for idiopathic pulmonary fibrosis ("IPF"); his sentence remains pending before the court. The jury found the defendant guilty of wire fraud related to a press release announcing the results of a clinical trial of Actimmune for the treatment of IPF. Although the clinical trial in fact failed, the press release portrayed that the results of the trial established that Actimmune helped IPF patients live longer. Specifically, the press release's headline falsely stated that "InterMune Announces Phase III Data Demonstrating Survival Benefit of Actimmune in IPF", with the subheading "Reduces Mortality by 70% in Patients with Mild to Moderate Disease."
- In California, a physician paid \$2.2 million to resolve FCA allegations that between 2002 and 2006, he inappropriately allowed his UPIN to be used to bill Medicare for respiratory therapy. The Federal government alleged that the claims were billed incident to his services and as if they were performed at his office, when he did not provide direct supervision and the services were provided at noncovered board and care facilities. The government also alleged that the physician paid kickbacks to "marketing coordinators," who recruited patients at the board and care facilities. As part of the settlement, he also agreed to be excluded for 15 years.
- In Florida, a physician paid \$1.7 million to settle allegations that he billed the Medicare program for higher levels of service than he actually rendered to patients and by billing for services not provided. To ensure payment of the judgment, the court permitted the government to seize five of his vehicles and garnish \$976,000 that the physician had

transferred to his wife. As part of the settlement, the physician entered into a five-year Corporate Integrity Agreement (CIA) with HHS/OIG.

- In Kansas, a cardiologist and his practice group, Galichia Medical Group, paid the United States \$1.3 million to settle allegations that they submitted claims for services not provided, and in other instances, claims were submitted without proper documentation. As part of the settlement, the cardiologist and the practice group entered into an Integrity Agreement (IA) with HHS/OIG.
- A Missouri physician, his wife, and three companies were sentenced to prison terms and/or fines for their roles in a scheme to bill Medicare and Medicaid for home visits that were either not provided or were provided by another physician who had been excluded from Federal health care programs. The Missouri physician was sentenced to 33 months in prison and ordered to pay the Federal Government \$983,140. His company was also ordered to pay the same amount. Two other companies were each ordered to pay a \$50,000 fine for their roles in the conspiracy.

Fraud by Other Practitioners

- In Mississippi, the owner of a physical therapy provider was sentenced to 3 years in prison and ordered to pay \$1.0 million in restitution following his guilty plea to making a false statement in a health care matter. Beginning in April 2003 and continuing through May 2005, the owner submitted claims to the Medicare program falsely claiming that in-home physical therapy/physical medicine services had been rendered by a medical director or by a licensed clinic employee under the physician's direct supervision. In fact, the services were provided by unlicensed and unsupervised employees.
- In Mississippi, the three owners of a physical therapy provider each pleaded guilty to misprision of a felony. One was sentenced to 6 months in prison, while the other two were each sentenced to 5 years' probation. The defendants were also held jointly and severally liable for \$102,639 in court-ordered restitution. The three owners concealed from authorities the fact that, from May 2004 to April 2005, their company fraudulently submitted claims to the Medicare program for physical therapy/physical medicine services that were not rendered by qualified or licensed individuals.
- A Missouri podiatrist and his practice paid \$425,000 to resolve their liability under the FCA. From January 2003 to October 2008, the podiatrist allegedly submitted claims to Medicare for complex podiatric surgical procedures when, in fact, only routine foot care was provided. As part of the settlement, the podiatrist agreed to be excluded from Federal health care programs for 5 years and the practice was permanently excluded.
- In Maryland, a State-licensed clinical specialist in child and adolescent psychiatric and mental health nursing was sentenced to 36 months of imprisonment and ordered to pay restitution in the amount of \$390,000 following her guilty plea to health care fraud. The

clinical specialist falsely billed Medicare, Medicaid, and private health care plans for services that she did not provide on hundreds of occasions from January 2003 to November 2007. She often billed for face-to-face psychotherapy services on dates when she was on vacation in other States or countries or attending out-of-town conferences.

- An Illinois podiatrist was sentenced to 12 months and 1 day of imprisonment and ordered to pay \$109,127 in restitution following his guilty plea to health care fraud. From 2002 to 2006, the podiatrist billed Medicare for surgical procedures that he had not actually performed, including the permanent removal of partial or complete toenails, bunion corrections, and the removal of bones from patients' feet.

Fraud by Pharmacies

- A Kentucky pharmacist was sentenced to 6 months of home incarceration on charges of health care fraud and the sale of prescription drug samples. In addition, he paid the Federal Government \$850,000 as a criminal forfeiture of proceeds from the criminal activity and an additional \$495,606 in an FCA settlement. During his guilty plea, the pharmacist admitted that from January 1, 2001, through December 1, 2004, he defrauded health care benefit programs, including Medicaid, by unlawfully billing those programs for pharmaceutical drug samples provided to patients. He also admitted that he unlawfully purchased, sold, and traded prescription drug samples.
- The Medicine Dropper, Inc., and its pharmacist owners (collectively, Medicine Dropper), paid the Federal Government \$500,000 plus interest to resolve allegations of violating the Controlled Substances Act (CSA) and to settle allegations of violating the FCA for submitting false claims to Medicaid for prescriptions for three Medicaid recipients. The Federal Government alleged that Medicine Dropper filled invalid Ketamine prescriptions and filled prescriptions that were not for a legitimate medical purpose. As part of the resolution of this matter, Medicine Dropper agreed to adopt reasonable and customary policies to prevent the use of its pharmacy for "doctor shopping," fill prescriptions using the correct Drug Enforcement Administration number for the physician, ensure that all required elements of the prescription are present prior to dispensing, and no longer dispense Ketamine products.
- A Rhode Island pharmacist and co-owner of a pharmacy was sentenced to 1 year and 1 day of incarceration and ordered to pay \$404,125 in joint and several restitution for illegally buying and selling pharmaceuticals and defrauding health care insurers. A co-defendant was sentenced to 30 months of imprisonment for his role in the scheme. The pharmacist supplied his co-defendant with the drug Vicodin, which the latter then sold on the street. The pharmacy also purchased HIV/AIDS drugs and controlled prescription drugs from beneficiaries through the co-defendant at one-third the cost of the purchase price from a legitimate drug wholesaler. Upon receiving the prescription drugs from him, the pharmacy repackaged them for redistribution to Medicare Part D and Medicaid beneficiaries at the

full reimbursement rate. Also implicated in connection with the scheme was a former North Providence Police officer, who was sentenced to 5 months of imprisonment and ordered to pay a fine of \$17,627 for misprision of a felony, tampering with a witness, and making false statements.

- In California, a defendant pleaded guilty to distributing drugs purported to be Viagra and Cialis without a prescription. In pleading guilty, the defendant admitted to operating Internet Web sites known as www.viagra-on-wheels.com and www.sexpills-on-wheels.com, which advertised delivery services specializing in local delivery or overnight mail delivery of brand-name prescription erectile dysfunction drugs, particularly Viagra and Cialis. The drugs that the defendant advertised and sold on these Web sites were drugs that he imported from the People's Republic of China and Mexico. They bore the labels "Viagra" and "Cialis" and contained the same active ingredients as those drugs. The defendant also admitted that the Web sites falsely stated that the drugs were approved by the U.S. Food and Drug Administration (FDA), that they were obtained directly from licensed pharmaceutical manufacturers, and that they were sold in compliance with FDA regulations. The court sentenced the defendant to serve a 6 month prison term to be followed by 12 months of supervised release, and to pay a \$20,000 criminal fine.
- Tennessee-based Kindred Healthcare, Inc., (Kindred) and its successor PharMerica Healthcare Pharmacy, LLC, agreed to pay \$1.3 million to settle allegations in a *qui tam* complaint that Kindred billed Medicaid for a higher number of drugs than were actually administered. In some cases, the overbilling was for multiple times the proper amount.

Hospital Fraud

- In Texas, Methodist Hospital paid \$9.9 million to resolve allegations of improperly increasing charges to Medicare patients in order to obtain enhanced reimbursement. In addition to its standard payment system, Medicare pays supplemental reimbursement called outlier payments, to hospitals in cases where the cost of care is unusually high. The Government alleges that for more than 2 years, Methodist Hospital improperly inflated charges for inpatient and outpatient care to make its costs for providing care appear greater than they actually were, thereby obtaining outlier payments from Medicare that it was not entitled to receive.
- In California, the principals and executives of the City of Angels Medical Center entered into a \$10.0 million consent judgment to resolve their joint and several liabilities for allegations that they conspired with, and paid kickbacks to recruiters who paid homeless Medicare and Medi-Cal beneficiaries to be admitted to the hospital, where unnecessary procedures were often performed.
- In Ohio, Regency Hospital Company, LLC, and three subsidiaries Regency Hospital of North Central Ohio, LLC; Regency Hospital of Odessa, LLP; and Regency Hospital of Northwest Arkansas, LLC, (collectively, Regency) paid \$9.8 million plus interest to

resolve their potential FCA liability. Regency Hospital Company, LLC, owns and operates 23 long term acute care hospitals (LTACH) in 10 States. The Federal Government contended that Regency violated the FCA by falsely certifying that the average length of stay at its facilities was greater than 25 days and, as a result, the LTACHs were reimbursed at the higher LTACH diagnosis related group (DRG) rate. However, the actual average length of stay entitled the facilities to be reimbursed only at the lesser acute care hospital DRG rate. Regency Hospital Company, LLC, also agreed to enter into a 5-year CIA.

- Six hospitals throughout Indiana and Alabama paid \$8.0 million to resolve FCA allegations that the hospitals overcharged Medicare from 2002 to 2008 by thousands of dollars for performing kyphoplasty, a minimally-invasive procedure used to treat certain spinal fractures, on an inpatient basis. The procedure can be performed safely as an outpatient surgery, but the Indiana and Alabama hospitals performed the procedure on an inpatient basis in order to increase its Medicare billings. The Indiana hospitals include St. Francis Hospital in Beech Grove, Deaconess Hospital in Evansville, and St. John's Hospital System in Anderson, which have agreed to pay the United States \$3,158,629, \$2,110,034, and \$826,256, respectively. The Alabama hospitals include St. Vincent's East Hospital, St. Vincent's Birmingham Hospital, and Providence Hospital in Mobile, which have paid the United States \$1.5 million, \$422,748, and \$381,713, respectively. These settlements follow the Government's May 2008 settlement with Medtronic Spine LLC, corporate successor to Kyphon, Inc., which paid \$75 million to settle allegations that it engaged in a scheme to defraud Medicare by counseling hospital providers to perform kyphoplasty procedures as an inpatient procedure.
- In Tennessee, Milan General Hospital paid \$5.3 million to settle civil allegations that between July 1, 1999 to December 2003, the hospital improperly admitted certain Medicare patients into its psychiatric unit, and that the hospital billed Medicare for lengths of stay in units that exceeded Medicare coverage criteria. As part of the settlement, the hospital entered into a 5-year CIA with HHS/OIG.
- In New Orleans, Louisiana, West Jefferson Medical Center paid the Federal Government and the State of Louisiana \$3.3 million to resolve allegations that the hospital overcharged the Medicaid program. The settlement resolves allegations made in a *qui tam* complaint that the hospital led the Medicaid program to believe that its Pediatric Intensive Care Unit had the capability to perform certain critical care services when, in fact, the unit did not possess such capability. As a result, Medicaid overpaid the hospital between March 1998 and October 2003. The investigation was conducted jointly with the Louisiana MFCU.
- In Tennessee, Jackson Madison General Hospital paid the Federal Government \$2.6 million to settle civil allegations that between July 1, 1997 to June 31, 2002, it submitted claims to Medicare for non-emergency transports for its beneficiaries that did not meet Medicare's medical necessity and documentation requirements. As part of the

settlement, the hospital entered into a 5-year CIA with HHS/OIG.

- In Maryland, Johns Hopkins Bayview Medical Center in Baltimore, Maryland paid \$2.8 million to settle *qui tam* allegations that it reported false secondary diagnoses for its inpatient hospital stays to Maryland's hospital rate setting commission, resulting in inflated reimbursement rates to the hospital. These false diagnoses included claims that patients suffered from malnutrition and acute respiratory failure when those conditions had not actually been diagnosed or treated during the patients' hospital stay.
- In New Haven, Connecticut, Yale New Haven Hospital paid \$885,953 to resolve allegations that it billed the Medicare program for medically unnecessary inpatient hospital admissions. The Federal Government alleged that from April 1, 1998, to March 31, 2002, instead of performing Gamma Knife radiosurgery procedures on an outpatient basis, as is typically done, the hospital admitted the patients for overnight stays and billed Medicare for inpatient admissions that were not medically necessary. This was in addition to similar improper billing practices that the hospital self-disclosed for the period from April 2002 to April 2006, and for which it voluntarily paid a refund of \$2.4 million.
- In Burlington, Massachusetts, Lahey Clinic Hospital, Inc. paid \$843,896 to settle allegations that it improperly submitted claims to Medicare for drug infusion therapy, chemotherapy, and blood transfusion therapy services for multiple units of these services when only one unit per date of service should have been billed to Medicare.
- Louisiana State University Health Science Center in Shreveport (LSUHSC-S) will pay \$706,677 to settle allegations that it defrauded the Federal Medicare program by billing for medical services that were never provided. Between 1995 and 2005, *qui tam* relators alleged that teaching physicians in the orthopedic department falsely claimed to have participated in orthopedic surgery cases performed by residents. In many cases the teaching physician was not present as required. LSUHSC-S then submitted the Part B claims to Medicare on behalf of the physicians and divided the Federal reimbursements between the hospital and the teaching physicians.
- In Huntington, West Virginia, Cornerstone Hospital of Huntington, LLC, paid the Federal Government \$690,000 to settle allegations made in a *qui tam* complaint that it billed for supplies and services not rendered, unbundled services, submitted duplicate claims, billed for supplies and services rendered without a physician's order, billed for supplies and services without regard to medical necessity, and billed for services rendered by unqualified providers.

Fraud by Laboratories

- Quest Diagnostics Incorporated (Quest) and its wholly owned subsidiary, Nichols Institute Diagnostics (NID), entered a global criminal and civil settlement to resolve allegations

raised in a *qui tam* complaint concerning various types of diagnostic test kits that NID manufactured, marketed, and sold to laboratories throughout the country between May 1, 2000 and April 30, 2006. As part of the criminal resolution, NID pleaded guilty to a felony misbranding violation relating to NID's Nichols Advantage Intact Parathyroid Hormone Immunoassay, a test used to measure parathyroid hormone (PTH) levels in patients, and agreed to pay a criminal fine of \$40.0 million. As part of the civil settlement, Quest, as the parent company of NID, paid \$262.0 million plus interest to resolve FCA allegations relating to the Advantage Intact PTH assay and four other assays manufactured by NID that allegedly provided inaccurate and unreliable results. Quest has also paid various State Medicaid programs approximately \$6.2 million to resolve similar civil claims. Quest entered a 5-year CIA.

- HMS Diagnostics, its affiliates, and its owner/operator (collectively, HMSD) paid \$564,532 to settle allegations that it submitted false claims for providing polysomnograph sleep tests. Medicare regulations required that technicians administering the test be properly certified. The technicians at HMS, an independent diagnostic testing facility (IDTF), did not hold the proper certification. In addition, IDTFs are required to submit the names of their licensed and certified staff members when they submit their Medicare/Medicaid application and are required to amend the application if the licensed or certified personnel change. HMSD also failed to adhere to this regulation. HMSD and its owner/operator have also entered into a 5-year CIA with HHS/OIG.

Fraud by Clinics

- In California, the owner and operator of a medical clinic was ordered to pay \$4.7 million in restitution and was sentenced to 72 months of incarceration following her guilty plea to health care fraud. The clinic paid a kickback to every patient or marketer bringing a patient into the clinic, billed for patients who never came to the clinic, and created patient files with falsified notes to support the fraudulent claims.
- In Florida, the owner of a clinic was sentenced to 70 months of incarceration and ordered to pay \$4.0 million in restitution following his guilty plea to charges of health care fraud. The clinic purportedly provided Medicare beneficiaries with Imiglucerase, Rituximab, Octreotide, and other infusion medications used to treat HIV/AIDS, non-Hodgkin's lymphoma, and Gaucher's disease. From March 31 through November 7, 2005, the owner, on behalf of the clinic, caused the submission of false and fraudulent claims for these drugs to Medicare.
- A Georgia man was sentenced to 52 months of incarceration and ordered to pay \$3.9 million in restitution following his guilty plea to conspiracy to commit health care fraud. With the assistance of co-conspirators, this individual set up a series of medical clinics that existed in name only. He was instrumental in leasing space in the names of the companies, opening bank accounts, incorporating the companies, and obtaining Medicare

billing numbers for them. The co-conspirators also improperly obtained identity information of actual doctors and Medicare patients. The fraudulent information was used to bill Medicare for infusion therapy services that were not rendered.

- Carlson Therapy Network, P.C., (Carlson) a network of 20 physical therapy clinics in Connecticut and Rhode Island, paid \$1.9 million and enter into a 5-year CIA to resolve its FCA liability. The Federal Government alleged that from October 2002 through December 2005, Carlson submitted false or fraudulent claims for individual, one-on-one physical therapy services when, in fact, group physical therapy services were provided.
- In Georgia, the three owners of a Savannah clinic were ordered to serve prison terms of 47, 20, and 6 months, respectively, and to pay a total of \$423,596 in restitution for their involvement in an infusion fraud scheme. The clinic billed Medicare for infusion therapy and gamma globulin that were not provided to patients. The investigation also revealed that the clinic paid patients to receive treatment at the facility.

Fraud by Medical Equipment Suppliers

- In Florida, the two owners of a medical billing company were each sentenced to 168 months in prison for health care fraud and conspiracy to commit health care fraud. In addition, an employee was sentenced to 132 months in prison for aggravated identity theft and conspiracy to commit health care fraud. The owners were ordered to pay \$125.7 million in restitution and forfeit various pieces of real estate. The medical billing company submitted claims to Medicare on behalf of suppliers who purportedly provided DME to Medicare beneficiaries. These claims were for equipment that had not been ordered by physicians or delivered to the beneficiaries as claimed.
- In Texas, the former owner of a DME supplier was sentenced to 60 months in prison and ordered to pay \$1.6 million in restitution to the Medicare and Medicaid programs for his role in defrauding Federal health care programs in a motorized wheelchair fraud scheme. The former owner billed for motorized wheelchairs which were either not required by the Medicare beneficiary or not delivered, or both. He purchased prescriptions for the equipment from several doctors and paid marketers to illegally recruit beneficiaries.
- An owner/operator of a Texas DME company, was sentenced to 70 months of imprisonment and was ordered to pay \$3.2 million in restitution following his guilty plea to health care fraud and wire fraud. A second owner/operator had previously been sentenced in July 2008 to one year and one day of incarceration and held responsible for paying \$1.6 million, a portion of the restitution figure, for conspiracy. According to allegations in a 35-count indictment, the DME company billed Medicare for motorized wheelchairs but routinely provided less expensive motorized scooters.

- In Florida, a DME company, Nationwide Medical, Inc. (Nationwide) and its president/CEO paid the Federal Government \$2.0 million for allegedly violating the anti-kickback statute. Between September 30, 2004, and June 25, 2007, Nationwide and its president allegedly entered into professional services agreements (PSA) with sleep labs and other health care providers (collectively, “sleep labs”) in multiple states. Under the PSAs, Nationwide provided continuous positive airway pressure (CPAP) devices and associated equipment to the sleep labs and paid the sleep labs a “set-up fee” each time a sleep lab provided Nationwide’s device and equipment to a patient. Nationwide submitted claims for reimbursement to Medicare for the delivery of the CPAP device and associated equipment, as well as for the monthly rental of the CPAP device and replacement supplies. Nationwide also entered into a 5-year CIA with HHS/OIG.
- In Florida, the president of a DME supplier was sentenced to 92 months in prison and ordered to pay the Federal Government \$1.3 million. Under the president’s direction, the DME supplier submitted approximately \$8.3 million in fraudulent claims to Medicare seeking reimbursement for DME items that had not been prescribed by physicians nor provided to Medicare beneficiaries, of which Medicare paid approximately \$1.3 million to the DME supplier.
- In Texas, the owner of a DME company was sentenced to 60 months in prison and ordered to pay the Federal Government \$804,344. The man unlawfully obtained Medicare patients’ identifying information and subsequently sold that information to several other medical equipment suppliers. These suppliers used the patients’ names, Medicare numbers, and other information to submit false claims to Medicare seeking reimbursement for providing power wheelchairs that generally cost Medicare about \$4,200 each.
- In Texas, the owner of Coastal Medical Supply was sentenced to 18 months of incarceration and ordered to pay \$702,963 in restitution for health care fraud and conspiracy to commit health care fraud. Through his DME company, the owner submitted claims to Medicare and Medicaid for reimbursement of motorized wheelchairs. In most cases, the owner provided Medicare and Medicaid recipients in both Texas and Louisiana either with less expensive scooters or nothing at all. As part of his scheme, he paid an employee of one of Texas’s largest not-for-profit hospital systems for fraudulent prescriptions, certificates of medical necessity, and Medicare patient information. The employee was sentenced to 5 years’ probation and ordered to pay restitution of \$19,221, jointly and severally with the owner, for receiving illegal kickbacks.
- A Florida man received a sentence of 121 months in prison and ordered to pay \$3.3 million in restitution for his role in orchestrating a multi-million dollar health care fraud and money laundering scheme. The man owned and controlled various DME companies in Miami, but used a series of “straw” owners to conceal his ownership. These DME companies collectively submitted more than \$16.5 million in false claims to Medicare for services and equipment that were never provided.

Fraud by Nursing Homes

- Regency Nursing and Rehabilitation Centers, Inc., (Regency) paid \$4.0 million plus interest to resolve its potential FCA liability for violations allegedly committed at 10 of its nursing facilities located in south, central, and east Texas. The allegations included submitting claims to Medicare and Medicaid for skilled services that were not medically necessary and/or were for patients who did not qualify for the claimed services. In addition, the Federal Government alleged that Regency falsely certified on its cost reports that all services had been provided in accordance with all applicable laws and regulations.
- Grant Park Care Center (GPCC), a 296-bed skilled nursing facility in Washington, D.C., paid the Federal Government and the District of Columbia \$2.0 million to settle FCA allegations. GPCC is owned and managed by Centennial HealthCare Corporation, Grant Park Nursing Home Limited Partnership, Grant Park Management, LLC, and several other legal entities (collectively, Centennial). The Federal Government alleged that from January 1998 through December 2007, Centennial submitted claims to the Medicare and Medicaid programs for services that failed to meet the needs of the residents at GPCC and that Centennial understaffed GPCC with knowledge that resident care would be compromised. As part of the settlement, Grant Park Nursing Home Limited Partnership and Grant Park Management agreed to enter into a 5-year CIA with HHS/OIG that required them to establish a detailed compliance program and retain an independent monitor to assess their quality assurance and quality improvement systems.
- In Alabama, the owner/operator of a business that provided consulting services to skilled nursing facilities (SNF) was sentenced to 18 months in prison and ordered to pay \$600,000 to the Federal Government. The owner/operator created documents to be used by her skilled nursing facility clients to prepare Medicare cost reports. She knew that these documents falsely stated the role physicians affiliated with her consulting company played in providing utilization review services to the SNFs. Medicare guidelines state that only payments made to physicians for their services on utilization review committees are allowable as costs on a cost report for a skilled nursing facility. Her husband was later sentenced to 24 months in prison for his role in the scheme.
- In Philadelphia, Pennsylvania, Willowcrest Nursing Home and Willow Terrace long-term nursing care residence settled allegations that arose from an investigation of Willowcrest's sub-standard pressure ulcer treatment and prevention, incontinence care, pain-management, nutrition, weight monitoring, infection control, and diabetic care. This quality-of-care settlement is the first in which a health care facility is required to hire a full-time physician assistant or nurse practitioner whose sole responsibility will be to regularly and continuously treat its residents. The settlement also provides that Willowcrest and Willow Terrace will, among other things, pay \$305,072 to the Medicaid program.

Mental Health Facilities

- In Arkansas, Brighter Futures Behavioral, Inc. ("BFBI"), a Newport, Arkansas corporation and former Medicaid Provider in the Arkansas Medicaid Program, pleaded guilty to an information charging it with health care fraud and will pay \$113,801 in restitution to the Arkansas Medicaid program. The charge against BFBI stems from its participation in the Medicaid program Rehabilitative Services for Persons with Mental Illness, which is a program limited to certified providers who offer core mental health services for the treatment and prevention of mental disorders. Beginning on or about January 1, 2006 and continuing until on or about December 31, 2008, BFBI, through its employees and agents, submitted claims to Medicaid for services that were not provided, and for services that were not properly documented. As part of its plea agreement, BFBI agreed to enter into a transition plan with the Arkansas Medicaid Program to ensure the diligent and timely transfer of patients and patient records to new providers.
- In Pennsylvania, the Youth and Family Centered Services, Inc. and its wholly owned subsidiary, Southwood Psychiatric Hospital, Inc. entered into a civil settlement agreement to resolve allegations in connection with billing of the Medicaid program for services to children and adolescents at three Psychiatric Residential Treatment Facilities. As part of the agreement, the defendants paid \$150,000 to reimburse Federal Medicaid funds, and have committed to make systemic improvements at the facilities, beyond what is required by state laws. Those improvements include the elimination of using prone (face-down) physical restraints of residents, and maintaining the staffing levels in excess of those required by Pennsylvania law.

Kickbacks

- Condell Health Network (Condell), parent corporation of Condell Medical Center, a 283-bed hospital in Illinois, paid the Federal Government and the State of Illinois \$36.0 million as a result of filing false claims for reimbursement. Condell disclosed its conduct. The settlement agreement calls for Condell to pay the Federal Government \$33.1 million to resolve claims relating to Medicare patients and \$2.9 million to the State of Illinois to settle claims relating to Medicaid patients. Condell admitted in the settlement agreement to leasing medical office space at rates below fair market value; giving improper loans to physicians; and providing hospital reimbursement to doctors who performed patient services without required written agreements.
- The University of Medicine and Dentistry of New Jersey (UMDNJ) paid the Government approximately \$8.3 million to settle allegations that it illegally paid kickbacks to cardiologists and caused the submission of false claims to Medicare. The settlement amount represents double damages for all monies paid out by Medicare based on improper physician referrals and kickbacks paid to the physicians. UMDNJ also entered into a five-

year CIA with HHS/OIG. In a related case, three cardiologists also entered into agreements to settle allegations that they received kickbacks in the form of salaries from UMDNJ and caused the submission of false claims, and have paid amounts totaling \$960,000.

- Six Nevada physicians paid between \$54,440 and \$212,575 each to resolve allegations that the physicians received kickbacks in exchange for patient referrals made to a nurse practitioner.
- Neurometrix, Inc., paid a criminal penalty of \$1.2 million as part of a deferred prosecution agreement and to pay civil damages in the amount of \$2.5 million plus interest to the Federal Government. From August 2004 through October 2006, Neurometrix marketed a device used by physicians to diagnose neuropathies in peripheral nerves and the spine by offering free boxes of supplies for the device. These supplies were then billed to Federal health care programs. In addition, Neurometrix caused physicians to improperly bill nerve conduction studies to Medicare under a higher code than was actually performed.
- Ferrell-Duncan Clinic, Inc., a medical practice comprised of approximately 100 physicians, has paid \$1.0 million plus interest to resolve the Federal Government's claims related to Medicare payments received under Ferrell-Duncan's contract with Cox Medical Centers. Beginning in January 1996, Ferrell-Duncan was alleged to have entered into prohibited financial arrangements with Cox Medical Centers that induced physicians to refer patients to Cox.

Other Medicare/Medicaid Fraud

- The State of New York and New York City paid \$540 million to settle allegations that they knowingly submitted, or caused to be submitted, false claims for reimbursement for school-based health care services, primarily speech therapy and transportation, provided to Medicaid eligible children from 1990 to 2001. In particular, the settlement resolves allegations that the State of New York knowingly failed to provide proper guidance to the districts and counties outlining the requirements for a service to be covered by the Medicaid program, failed to monitor the districts and counties for compliance as required by the program and passed on claims to the Federal Government for services it knew were not covered or properly documented, all to make the United States pay a larger share of New York's Medicaid costs.
- The owner/operator of a mobile dental unit, was sentenced to 41 months of imprisonment and ordered to pay restitution in the amount of \$1.7 million following a guilty plea to health care fraud and money laundering charges. The mobile clinic operated out of a recreational vehicle and focused primarily on low-income, Medicaid-eligible children. The mobile unit arranged for visits, typically to inner city schools, day care facilities, and subsidized housing projects. The owner routinely billed Medicaid for fillings when

sealants were actually applied to primary teeth, a procedure not covered by Medicaid. He also improperly billed for X-rays that were not taken at the direction of a dentist, were not diagnostic, or were developed long after the patient was seen on the mobile unit.

- In Indiana, a man was sentenced to 43 months of incarceration and ordered to pay \$964,852 in restitution for his guilty plea to health care fraud charges. The investigation revealed that he received payments from Medicaid by having his business partner bill for transportation services purportedly provided to Medicaid beneficiaries from August 2006 through December 2008. The defendant had obtained approximately 160 Medicaid numbers of nursing home patients with developmental disabilities and used these numbers to submit the false claims to Medicaid. The defendant, who was previously convicted of health care fraud, hid his involvement in the scheme by having the Medicaid provider number registered to one of his former employees.
- Chesapeake Youth Center (CYC), a former residential treatment center for adolescents located in Cambridge, Maryland, paid \$259,120 to resolve its potential FCA liability. The Federal Government alleged that from January through July 2005, CYC submitted or caused to be submitted claims to Medicaid for inpatient adolescent psychiatric services that were not provided or were substandard or worthless. The investigation was conducted jointly with the Maryland MFCU.

Other Fraud

- In Connecticut, Yale University paid \$7.6 million to resolve FCA allegations that it engaged in unallowable transfers of funds received on Federal research grants, and also submitted inaccurate time or effort reports involving such grants. The vast majority of the grants at issue were provided by the Department of Health and Human Services, the National Science Foundation, the Department of Energy, the Department of Defense, or the National Aeronautics and Space Administration.
- In Maine, the former Governor of the Passamaquoddy Tribe, Indian Township Reservation, was convicted on 29 of 30 counts of fraud, including several health care fraud offenses, after a two-week jury trial in Bangor. The former Finance Director at Indian Township, was also convicted of 11 of 29 counts of fraud. With respect to the health care benefit programs, the jury found that the defendants diverted more than \$305,000 in funds awarded to the tribe by the U.S. Department of Health and Human Services, Indian Health Services, for the benefit of the tribe's Indian Health Center. In addition, the defendants diverted more than \$195,000 awarded to the tribe by the Substance Abuse and Mental Health Services Administration to be used by the tribe's substance abuse and HIV prevention program. The evidence established that the former Governor diverted some of the restricted funds to benefit himself, his family, and other tribal members with whom he carried favor. The former Tribal Governor was sentenced to serve 60 months in prison and ordered to pay restitution in the amount of \$1.7 million.

The former Finance Director was sentenced to 1 year and 1 day in prison and held jointly liable for paying restitution in the amount of \$1.6 million.

- Alabama-based SouthernCare, Inc. (SCI), several affiliated entities, and SCI executive paid the Federal Government \$24.7 million and enter into a 5-year CIA to resolve their FCA liability for allegedly submitting false claims to Medicare. Operating in locations in 15 states, SCI allegedly submitted claims for treating patients who did not meet Medicare's hospice eligibility criteria. This settlement resolved allegations in two *qui tam* lawsuits filed by former SCI employees.
- Medical transcription service provider MedQuist, Inc., paid the Federal Government \$6.6 million to resolve FCA allegations that it overbilled Federal Government clients. The Federal Government alleged that from approximately 1998 through 2004, the New Jersey-based company knowingly overbilled the Department of Veterans Affairs, the Department of Defense, and the Public Health Service for medical transcription services by inflating the number of lines billed to the Federal Government instead of applying the contractually prescribed method. The settlement resolves in whole or in part allegations made in two *qui tam* actions.
- The owner of a Georgia health care company was sentenced to 51 months' imprisonment and ordered to pay \$1.0 million in restitution in connection with a scheme to defraud Medicare by billing \$3.4 million of phony HIV infusion services which were never provided. The company, called Longevity Care Services, recruited Medicare patients and then billed Medicare on their behalf for fictitious infusion services.
- An ambulance service provider was sentenced to 5 years probation and ordered to pay to the Federal Government \$2.2 million after pleading guilty to filing false claims to Medicare and the Illinois Medicaid program. The provider also pleaded guilty to charges related to embezzlement and mail fraud. In a related matter, the former president was sentenced to 57 months in prison for failing to pay over Federal employment taxes.
- In Texas, two brothers were each sentenced to 30 months' imprisonment and were ordered to pay \$637,425 in restitution for their involvement in a scheme to defraud Medicare and Medicaid. The two owned and operated an ambulance company that specialized in transporting dialysis patients to and from their treatments. Many of their patients did not qualify for transportation and either had no prescriptions or used prescriptions on which the doctors' signatures were either photocopied or procured by trickery. In addition, the brothers purchased public transportation manifests to recruit patients and paid kickbacks to those patients. The two previous owners of the ambulance company were each previously sentenced to time served and ordered to pay \$1.7 million in restitution. A third previous owner was also charged but remains a fugitive.

- Three cardiologists in Arizona paid \$355,000 to settle allegations that from January 2007 to October 2007, they submitted claims for payment to the Medicare Program in violation of the physician self-referral laws. The three cardiologists owned an independent diagnostic testing facility (IDTF). Services provided to patients referred to the IDTF by the owner/physicians were improperly billed to Medicare.

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/OIG¹¹. In FY 2009, the Secretary and the Attorney General jointly allotted \$177.205 million to the HHS/OIG.

The HHS/OIG participated in investigations or other inquiries that resulted in 1065 prosecutions or settlements in FY 2009, of which 902, or 85 percent, were health care cases. A number of these are highlighted in the Accomplishments section. During FY 2009, the HHS/OIG excluded a total of 2,556 individuals and entities. Among these were exclusions based on criminal convictions for crimes related to Medicare and Medicaid, or to other health care programs; for patient abuse or neglect; or as a result of licensure revocations. In addition, HHS collected approximately \$360.2 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 2009, HHS/OIG reported that legislative and administrative actions to make funds available for better use resulted in an estimated \$16.47 billion in health care savings attributable to FY 2009 – \$5.5 billion in Medicare savings and \$10.97 billion in savings to the Federal share of Medicaid. 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>.

¹¹In addition to the funds made available to OIG from the HCFAC account under HIPAA, Congress also provided funds to OIG on a temporary basis specifically for oversight of the Medicaid program. The Deficit Reduction Act of 2005 (DRA, P.L. 109-171) appropriated \$25 million to the OIG for “Medicaid fraud and abuse control activities” for each of fiscal years 2006 through 2010. Therefore, OIG’s FY 2009 Medicaid-related activities cited throughout this report, including the activities discussed below, may draw on funding from both the HCFAC and DRA sources. Also, the Supplemental Appropriations Act of 2008 (Pub. L. 110-252) at § 7001(b), appropriated \$25 million to HHS/OIG in FY 2009 “for purposes of reducing fraud and abuse in the Medicaid program. Finally, the American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5) at § 5007(b) appropriated \$31.25 million to the HHS/OIG “for purposes of ensuring the proper expenditure of Federal funds under [Medicaid],” available for FYs 2009-2011.

Exclusions

One important mechanism for safeguarding the care provided to program beneficiaries is through exclusion of providers and suppliers who have engaged in the abuse or neglect of patients or fraud from participation in Medicare, Medicaid, and other Federal health care programs. During FY 2009, the HHS/OIG excluded a total of 2,556 individuals and entities. Among these were exclusions based on criminal convictions for crimes related to Medicare and Medicaid (780), or to other health care programs (277); for patient abuse or neglect (239); or as a result of licensure revocations (895). This list of conduct is not meant to be exhaustive, but identifies the most prevalent causes underlying HHS/OIG's exclusions of individuals or entities in FY 2009. Exclusion actions by HHS/OIG included:

- An Administrative Law Judge (ALJ) issued a decision affirming OIG's determination to exclude three former Purdue Frederick executives from participation in Federal health care programs for a period of 15 years. The exclusions were based on the executives' convictions for their failure as responsible corporate officers of Purdue Frederick to "prevent or correct" the fraudulent misbranding and distribution of OxyContin. In July 2007, when Purdue Frederick pleaded guilty to felony misbranding of OxyContin, the three executives pleaded guilty to related misdemeanor misbranding in their role as responsible corporate officers. In sustaining the 15-year period of exclusion, the ALJ found that the executives' fraud-related conduct "endangered the health and safety of program beneficiaries and others" and caused "astronomical" losses to Government programs.
- A Michigan osteopath was excluded for a minimum period of 50 years based on his conviction for health care fraud. From August 2001 to December 2004, the osteopath lied to his patients about their medical conditions and submitted claims to Medicare, TRICARE (the military's health insurance program), and private insurance companies for upcoded surgical procedures and medically unnecessary procedures. He was previously sentenced to 126 months of incarceration, was ordered to pay \$1.3 million in restitution, and had his osteopath license revoked by the Michigan Board of Osteopathic Medicine.
- The president and chairman of the board of Pleasant Care Corporation (Pleasant Care) agreed to be permanently excluded from Federal health care programs following an investigation of substandard care at nursing homes formerly operated by Pleasant Care. The exclusion of the president/chairman is the result of an OIG investigation of allegations that he, through his management and oversight of Pleasant Care, caused services to be furnished to Pleasant Care residents that substantially departed from the professional standard of care, and that put residents at risk for harm.
- An unlicensed esthetician in New York was excluded for a minimum of 15 years based on a jury conviction related to the serious injury she caused to two of her clients when she injected a silicone-type substance into their faces. The esthetician's actions caused deformities, impairment, and permanent scarring to her clients' faces, requiring them to undergo multiple reconstructive surgeries. She was sentenced to 5 years of incarceration.

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 Federal 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. HHS/OIG has continued to pursue its affirmative enforcement actions under these authorities. Examples include:

- An Administrative Law Judge sustained OIG's determination to impose a \$50,000 CMP against St. Joseph's Medical Center (St. Joseph's) for failure to provide a medical screening examination or stabilizing treatment to an individual who presented to the emergency department (ED) with an acute emergency medical condition. The patient's condition deteriorated after waiting several hours in the ED, and despite his family's repeated requests for help, the patient did not receive a medical screening examination. Approximately 3½ hours after arriving at St. Joseph's, the patient went into cardiopulmonary arrest and subsequently died.
- In Loxahatchee, Florida, Palms West Hospital paid \$50,000 to resolve allegations that it refused to accept requests to transfer two individuals from emergency departments at nearby hospitals. In both instances, the individuals had unstable emergency medical conditions that the transferring hospital could not stabilize. The first instance involved a 38-year-old woman with a suspected ectopic pregnancy. The obstetrician/gynecologist refused to accept the transfer of this patient because he felt that the patient should be taken to a hospital closer to the transferring hospital. The second instance involved a 60-year-old man with a fracture/dislocation of his shoulder. The on-call physician at Palms West Hospital refused to accept the transfer.
- Plantation General Hospital paid \$40,000 to resolve allegations that it failed to provide an appropriate medical screening examination, stabilizing treatment, and/or an appropriate transfer to a 22-year-old pregnant woman who presented to its ED. The woman told the ED staff that her doctor said she could deliver any time and that she was leaking fluid and having contractions. The nurse then reported to the woman that she had to go to another hospital, about a half hour away, to deliver her child. When the woman expressed worry about whether she could get to the other hospital in time and requested ambulance transport, the nurse told her that she could not help her and that she must go to the other hospital. A friend drove the woman at very high speeds to the other hospital where she delivered shortly after arrival.
- West Valley Imaging Limited Partnership and two physicians agreed to pay \$2 million plus interest and to enter into a 5-year integrity agreement for allegedly violating the CMPL. West Valley allegedly performed radiology tests and exams that were not ordered by Medicare beneficiaries' treating physicians.

Audits and Evaluations

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

Medicaid Outpatient Prescription Drug Expenditures

In reviews of the Medicaid outpatient prescription drug expenditures in five States, HHS/OIG found that the States had claimed Federal Medicaid reimbursement for prescription drug expenditures that did not fully comply with Federal requirements. CMS instructs States to use the quarterly Medicaid drug tape to verify coverage of the drugs for which they claim reimbursement.

- In Tennessee, HHS/OIG found that of the \$4.5 billion (\$3 billion Federal share) claimed, \$8 million (Federal share) represented expenditures for drug products that were not eligible for Medicaid coverage because their termination dates had passed or because the drugs were determined to be less than effective. An additional \$13.2 million (Federal share) represented expenditures for drug products that were not listed on CMS's quarterly drug tapes. HHS/OIG recommended, among other things, that the State refund the \$8.0 million to the Federal Government and that it work with CMS to determine whether the \$13.2 million in payments for drugs not listed on the quarterly drug tapes was eligible for Medicaid coverage.
- HHS/OIG's review of Pennsylvania's claims for reimbursement of Medicaid outpatient drug expenditures for FYs 2004 and 2005 found that of the State's \$1.96 billion (\$1.1 billion Federal share) in Medicaid outpatient claims, \$4.4 million (Federal share) represented expenditures for drug products that were not eligible for Medicaid coverage because, for example, the drugs were terminated or the drug expenditures were not supported by adequate documentation. An additional \$5.9 million (Federal share) represented expenditures for drug products that were not listed on the quarterly drug tapes. HHS/OIG recommended, among other things, that the State refund \$4.4 million to the Federal Government and that it work with CMS to resolve \$5.9 million in payments for drugs that were not listed on the quarterly drug tapes.

- HHS/OIG found that for FYs 2004 and 2005, California claimed \$24.0 million (Federal share) for unallowable Medicaid expenditures, which included \$21.0 million in unsupported drug expenditures and \$3.0 million in drug expenditures that were not eligible for Medicaid coverage because the drugs were dispensed after their termination dates. In addition, the State claimed \$10.9 million (Federal share) for drug products not listed on the quarterly drug tapes for which the State did not provide conclusive evidence that the drugs were eligible for Medicaid coverage. HHS/OIG recommended, among other things, that the State refund \$24.0 million (Federal share) to the Federal Government for unallowable drug expenditures, and work with CMS to resolve \$10.9 million (Federal share) in expenditures for drug products that were not listed on the quarterly tapes and that may not have been eligible for Medicaid coverage.
- In Michigan, the State claimed Medicaid reimbursement for \$106,000 (Federal share) in FY 2005 for outpatient expenditures for drug products that were not eligible for Medicaid coverage because they were dispensed after their termination dates or less than effective. In addition, the State claimed \$2.9 million (Federal share) for drug products that were not listed on the CMS quarterly drug tapes. HHS/OIG recommended, among other things, that the State refund \$106,000 to the Federal Government for drug expenditures that were not eligible for Medicaid coverage, and work with CMS to resolve \$2.9 million in payments for drugs that were not listed on the quarterly drug tapes and that may not have been eligible for Medicaid reimbursement.
- In New York, the State claimed Medicaid reimbursement for \$1.2 million (Federal share) in FYs 2004 and 2005 for outpatient expenditures for drug products that were not eligible for Medicaid coverage because they were dispensed after their termination dates, less than effective, or inadequately documented. In addition, the State claimed \$16.2 million (Federal share) for drug products that were not listed on the CMS quarterly drug tapes. HHS/OIG recommended, among other things, that the State refund \$1.2 million to the Federal Government for drug expenditures that were not eligible for Medicaid coverage, and work with CMS to resolve \$16.2 million in payments for drugs that were not listed on the quarterly drug tapes and that may not have been eligible for Medicaid reimbursement.

Medicaid Overpayments in Indiana

- Based on an audit of Indiana's Medicaid Rehabilitation Option Program for FYs 2000-2005, HHS/OIG found that the State did not report overpayments totaling \$23.4 million (\$14.5 million Federal share) and interest earned on the overpayments totaling \$130,000 (\$82,000 Federal share) in accordance with Federal requirements. States are required to refund the Federal share of Medicaid overpayments and to report to CMS any interest earned on overpayments each quarter. HHS/OIG recommended that, among other things, the State report to CMS Medicaid overpayments totaling \$23.4 million, refund \$14.5 million, and report interest earned on Medicaid recoveries totaling \$130,000 and refund \$82,000.

Medicaid Payments for Personal Care Services

- In a review of claims for personal care services (PCS), HHS/OIG found that New York State improperly claimed Federal Medicaid reimbursement for some personal care claims submitted by providers in New York City during CYs 2004 through 2006. PCS – such as dressing, bathing, cooking, and light housekeeping – help beneficiaries stay in their homes rather than receive constant care in more expensive institutional settings. Of the 100 claims in the random sample, 80 claims complied with Federal and State requirements, but 18 claims did not. HHS/OIG could not determine whether the two remaining claims, which involved services under the State’s Consumer Directed Personal Assistance Program, complied with Federal and State requirements. Based on the sample results, HHS/OIG estimated that the State improperly claimed \$275.3 million in Federal Medicaid reimbursement during the audit period. HHS/OIG recommended, among other things, that the State refund \$275.3 million to the Federal Government.
- In a related study, HHS/OIG reviewed Medicaid payments for PCS made by five State Medicaid programs from October 1 through December 31, 2005, and found that four States paid 871 claims to providers that had billed for more than 24 hours of PCS in a day. Although it is possible that beneficiaries with serious medical conditions may require a level of care that results in claims for PCS services exceeding 24 hours, such situations would be rare. HHS/OIG also found that the Medicaid programs in all five States paid 2,324 PCS claims, totaling \$3.0 million, which were associated with billings of between 16 and 24 hours of services per day. Although the report had no recommendations, HHS/OIG suggested that CMS consider providing States with information regarding the vulnerability associated with claims for PCS billed more than 24 hours per day or claims for date ranges that include days on which no services were provided.

Medicaid Disproportionate Share Hospital Payments

- HHS/OIG reviewed whether three hospitals associated with universities in Pennsylvania retained Medicaid DSH payments that are authorized by CMS to ensure that services are provided to the medical assistance population and help offset medical education costs incurred. States are required to make Medicaid DSH payments to hospitals that serve a disproportionately large number of low-income patients. HHS/OIG determined that two of the three hospitals did not retain their DSH payments but instead redirected payments totaling \$35.1 million (Federal share) to their university medical schools. Because the two hospitals did not require the medical schools to account for how they used the funds, HHS/OIG could not determine whether the schools used the DSH funds in compliance with the State plan. HHS/OIG’s recommendations included the recommendation that the State work with CMS to resolve \$35.1 million (Federal share) in DSH payments redirected to university medical schools.

Medicaid Family Planning Services

- Based on an audit of New York's claims for Federal Medicaid reimbursement for family planning services from April 2003 through March 2007, HHS/OIG estimated that the State improperly received \$17.2 million for improperly claiming enhanced 90-percent Federal reimbursement. Under Federal law, a State may provide family planning services and supplies to individuals of childbearing age who are eligible under the State Medicaid plan and receive enhanced 90-percent Federal reimbursement for items and procedures that are clearly furnished or provided for family planning purposes. HHS/OIG's recommendations included the recommendation that the State refund \$17.2 million to the Federal Government.
- In another study of New York's claims for family planning services, HHS/OIG found that the State improperly claimed enhanced 90-percent Federal reimbursement for inpatient family planning claims submitted by hospitals. Of the 173 claims in our sample, 3 qualified as family planning services and could be claimed at the enhanced 90 percent Federal reimbursement rate. However, the remaining 170 claims could not be claimed as family planning services or could be claimed only in part as family planning services. Based on these sample results, HHS/OIG estimated that the State received \$2.6 million in unallowable Federal Medicaid reimbursement. HHS/OIG recommended, among other things, that the State refund \$2.6 million to the Federal Government.

Medicaid Prescription Drugs

- HHS/OIG found that manufacturers typically categorize their drugs in the average manufacturer price (AMP) file in the same manner as national compendia. However, a manual review of drug categorizations identified (1) a potential problem with Medicaid payment for drugs that do not have FDA approval and (2) instances in which certain drugs appear to have been categorized incorrectly in the AMP file, thus resulting in a loss of rebates for States. For Federal payments to be available for covered outpatient drugs provided under Medicaid, drug manufacturers must pay quarterly rebates to State Medicaid agencies and provide CMS with the AMP for each national drug code (NDC) they market. In addition, for Medicaid Federal payment to be available, most covered outpatient drugs must be approved by FDA for safety and effectiveness, with certain exceptions. Drugs with matching drug categorizations accounted for 90 percent of NDCs and 97 percent of Medicaid expenditures under review. However, a manual review of 75 high-expenditure non-matching NDCs revealed that over 40 percent of the NDCs that underwent manual review were associated with unapproved drugs. Based on the findings of this report, HHS/OIG recommended, among other things, that CMS work closely with FDA to identify drugs not approved for safety and effectiveness by FDA and therefore potentially ineligible for Medicaid Federal financial participation; and work with manufacturers to determine the correct categorizations of the drugs identified in this report.

Eligibility to Participate as a Medicaid Hospital

- For the period from July 1, 1996, through June 30, 2007, HHS/OIG found that Indiana paid \$26.2 million (\$16.3 million Federal share) to a hospital that was not eligible to receive Medicaid payments for inpatient psychiatric services. The hospital did not meet Federal Medicaid eligibility requirements because it did not demonstrate compliance with two special Medicare Conditions of Participation requirements. HHS recommendations included the recommendations that the State refund \$16.3 million to the Federal Government for Medicaid inpatient psychiatric service payments made to the hospital and that the State identify and refund the Federal share of additional unallowable Medicaid payments to the hospital for inpatient psychiatric services provided after the audit period.

Medicaid Targeted Case Management Services

- HHS/OIG found that Pennsylvania's claims for targeted case management (TCM) services did not always comply with Federal and State requirements. Federal law authorizes State Medicaid agencies to provide case management services to Medicaid beneficiaries. These services are referred to as TCM when they are furnished to specific populations in a State. Based on its review of 375, 36 claims were unallowable because the services were unsupported by case records or insufficiently documented. As a result, HHS/OIG estimated that during CYs 2003 through 2005, the State claimed \$11.9 million (\$6.5 million Federal share) in unallowable TCM costs. HHS/OIG recommended, among other things, that the State refund to the Federal Government the \$6.5 million for unallowable TCM services.

Adverse Events

- To comply with a Congressional mandate, HHS/OIG issued four reports related to events that harm patients as a result of medical care ("adverse events"), such as infection associated with use of a catheter, and events, such as surgery on the wrong patient, that the National Quality Forum (NQF) has deemed "should never occur in a healthcare setting" ("never events"). In the first report, an overview of key issues, HHS/OIG found that reducing the incidence of adverse events is a high priority for policymakers, patients, and providers and that new policies, such as Medicare's nonpayment for care associated with events and public disclosure of events, strengthen hospitals' incentives to develop safer practices. In a second report, on state reporting systems, HHS/OIG determined that 26 States had adverse event reporting systems that collect data regarding adverse events that have taken place in hospitals and other health care settings. However, there was no national adverse event reporting system nor any Federal standards regarding State systems. HHS/OIG found variations among the 26 State systems, making their data unsuitable for use in the aggregate to identify national incidence and trends. In a third report, "Incidence Among Medicare Beneficiaries in Two Selected Counties," HHS/OIG found that during a 1-week period in August 2008, 15 percent of hospitalized Medicare beneficiaries in two selected counties experienced an adverse event during their hospital stays. HHS/OIG identified another 15 percent of Medicare beneficiaries who experienced events that resulted in temporary harm. Although not nationally

representative, these results substantiate concerns about the incidence of adverse events in hospitals and the importance of safety initiatives to reduce occurrences. A nationwide study of adverse events in hospital settings is underway.

Medicare Inpatient Rehabilitation Facilities

- Inpatient rehabilitation facilities (IRF) did not always bill correctly for interrupted stays with discharge dates during CYs 2004 and 2005. HHS/OIG's nationwide computer match showed that 448 IRFs billed incorrectly for 986 interrupted stays during that period. If a Medicare inpatient is discharged from an IRF and returns to the same IRF within 3 consecutive calendar days, the IRF should combine the interrupted stay into a single claim and receive a single discharge payment. HHS/OIG determined that the correct value of the stays was \$17.5 million, rather than the \$21.7 million that the IRFs billed. As a result, Medicare made net overpayments of \$4.2 million to the IRFs. HHS/OIG recommended that CMS direct its fiscal intermediaries to recover the \$4.2 million in net overpayments.

High Dollar Payments for Medicare Inpatient Services

- HHS/OIG issued four reports on high-dollar payments that fiscal intermediaries (intermediaries) made to hospitals for inpatient services claimed under Medicare Part A. HHS/OIG defined high-dollar payments as those that were \$200,000 or more each. CMS contracts with intermediaries to, among other functions, process and pay Medicare Part A (inpatient) claims submitted by providers. For an intermediary for Wisconsin and Michigan, the review identified overpayments to hospitals totaling \$1.6 million for 107 high-dollar claims. For an intermediary for Florida, the review identified \$1.7 million in overpayments for 125 high-dollar claims. For an intermediary for Illinois, Indiana, Kentucky, and Ohio, the review identified net overpayments totaling \$7.4 million. Finally, for an intermediary that operates in all States, except for New York, HHS/OIG identified \$3.9 million in overpayments to hospitals for 221 high-dollar claims. In all these reviews, HHS/OIG recommended, among other things, that the intermediaries recoup the overpayments.

Medicare Contractor Costs

HHS/OIG conducted a series of reviews examining costs claimed by Medicare contractors.

- In three reviews of contractors' costs in Kansas, Maryland and Utah, HHS/OIG determined that the contractors' termination claims of \$11.2 million, \$1.5 million, and \$1.4 million, respectively for post-retirement benefit (PRB) costs were unallowable, because the claims were based on retroactive changes to the contractors' accounting procedures. Therefore, and pursuant to the Medicare contracts, none of the costs claimed were allowable for Medicare reimbursement. HHS/OIG recommended that the claims be withdrawn.
- In Puerto Rico, a Medicare contractor claimed \$2.9 million of unallowable Medicare pension costs for FYs 1988 through 2006, primarily because the contractor calculated pension expense

using a standard intended for financial reporting. HHS/OIG calculated the allowable pension costs to be \$4.1 million, and recommended that the contractor reduce its Final Administrative Cost Proposal pension costs by \$2.9 million or refund this amount to CMS and ensure that future pension cost claims are in accordance with the Medicare contracts.

- In a study of another contractor's PRB costs, HHS/OIG found that the contractor understated its Medicare segment PRB assets as of January 1, 2006, by \$2.4 million. In claiming costs for PRB plans, contractors must follow cost reimbursement principles contained in the Federal Acquisition Regulation and applicable Cost Accounting Standards, as required by the Medicare contracts. As part of a change in its accounting practice, the contractor was required to identify and update the Medicare segment's PRB assets. However, the contractor made errors in its update computations. In addition, the contractor did not make adjustments for participants who transferred in and out of the Medicare segment. HHS/OIG recommended that the contractor increase the Medicare segment PRB assets by \$2.4 million as of January 1, 2006, and make adjustments for participant transfers in future updates.
- In a review of an Ohio contractor's PRB costs, HHS/OIG determined that the contractor needed to refund the Federal Government \$14.9 million. The contractor did not correctly identify the initial allocation of pension plan assets to the Medicare segment or comply with the requirements for updating assets. In addition, the contractor did not properly determine Medicare's share of the Medicare segment excess pension assets as of the termination of the Medicare contracts. HHS/OIG recommended, among other things, that the contractor refund to the Federal Government \$14.9 million.

"Currently Not Collectible" Medicare Overpayments

- In a review of 10 suppliers of DME with total outstanding Medicare debt of \$7.3 million, HHS/OIG found that 6 suppliers were associated with 15 other suppliers and home health agencies (HHA) that collectively received \$58 million in Medicare payments during 2002-2007. The associations are of interest because Federal investigators suspect that principals of DME suppliers with outstanding Medicare debt may be benefiting from Medicare payment through businesses publicly fronted by associates or family members. Most of the DME suppliers associated with the six suppliers had themselves lost billing privileges by January 2005 and had collectively accumulated \$6.2 million of their own "currently not collectible" debt to Medicare; however, most associated HHAs received Medicare payments as recently as December 2007. This suggests that associations among DME suppliers and HHAs may be less frequently detected than those among DME suppliers alone. The sample DME suppliers we reviewed were most frequently connected with their associated DME suppliers and HHAs through shared owners or managers. Further, 11 of the 15 associated businesses' enrollment applications did not include the name of at least one individual listed as an owner or a manager in public records. These results suggest that suppliers associated with Medicare debt could inappropriately receive Medicare payments by omitting owner/manager information on their enrollment applications and working through

other DME suppliers and HHAs. HHS/OIG intends to conduct follow-up work regarding the issues and vulnerabilities identified in this early alert memorandum.

Medicare Hospice Benefit Coverage Requirements

- HHS/OIG's medical record review determined the extent to which hospice claims for beneficiaries in nursing facilities in 2006 met Medicare coverage requirements. The review found that 82 percent of sampled hospice claims for beneficiaries in nursing facilities did not meet at least one Medicare coverage requirement. HHS/OIG also found that 33 percent of claims did not meet election requirements and that 63 percent of claims did not meet plan-of-care requirements. For 31 percent of claims, hospices provided fewer services than outlined in beneficiaries' plans of care. For four percent of claims, the certifications were missing or did not meet one or more Federal requirements. HHS/OIG recommended that CMS educate hospices about the coverage requirements and their importance in ensuring quality of care, provide tools and guidance to hospices to help them meet the coverage requirements, and strengthen its monitoring practices regarding hospice claims.

Billing with Inactive or Invalid Physician Identifiers

- In its review of Medicare payments for medical equipment and supply claims, HHS/OIG found that Medicare allowed almost \$34 million in 2007 for medical equipment and supply claims with unique physician identification numbers (UPIN) that had never been issued or had been deactivated by CMS. HHS/OIG also found that Medicare allowed over \$6 million in 2007 for claims with invalid UPINs that had never been issued by CMS. During the same year, Medicare also allowed almost \$28 million for claims with UPINs that CMS had deactivated; including \$5 million for claims with a date of service after the physician identified on the claims had died. Medicare also allowed over \$300,000 for claims with invalid referring physician national provider identifiers in 2007. HHS/OIG recommended, among other things, that CMS determine why Medicare claims with identifiers associated with deceased referring physicians continue to be paid.

Medicare's Postacute Care Transfer Policy

- In its nationwide review of hospital compliance with Medicare's postacute care transfer policy, HHS/OIG estimated that for the 3-year period that ended September 30, 2005, hospitals improperly coded 15,051 claims, resulting in Medicare overpayments of \$24.8 million. Under the postacute care transfer policy, Medicare pays full prospective payments to hospitals that discharge inpatients to their homes. For specified diagnosis-related groups, Medicare generally pays a lesser amount to hospitals that transfer inpatients to certain postacute care settings, such as SNFs or home health care. Most of the overpayments in the sample of 150 claims occurred because CMS lacked adequate payment system controls before implementing a system edit on January 1, 2004, to detect transfers improperly coded as discharges to home. HHS/OIG recommended that CMS instruct the fiscal intermediaries to recover \$137,000 in overpayments identified in our sample, review the remaining claims in

our sampling frame, and identify and recover additional overpayments estimated at \$24.7 million.

Medicare Part A Skilled Nursing Facility Stays

- HHS/OIG found that Medicare Part D paid for 1.2 million prescription drug events, amounting to \$75 million, for beneficiaries in Part A SNF stays in 2006, and that the majority of these payments were most likely inappropriate. Medicare Part D covers most prescription drugs; however, it generally excludes drugs that are covered under Medicare Parts A or B. Sixty percent of the drugs Part D paid for while beneficiaries were in Part A SNF stays in 2006 were dispensed by long-term care pharmacies. These pharmacies dispense drugs for use in long-term care settings, including SNFs. Because these drugs are generally dispensed for use in the facility during a Part A SNF stay, Part D payments for them, which amounted to \$41.3 million, were most likely inappropriate. The remaining 40 percent of drugs paid for by Part D for beneficiaries in Part A SNF stays were dispensed by retail and other types of pharmacies. If these drugs were for use in the facility or were to facilitate the beneficiaries' discharges, then Part D payments were also inappropriate. HHS/OIG recommended, among other things, that CMS ensure that Part D payments for drugs for beneficiaries in Part A SNF stays are appropriate.

Medicare Reimbursement for Power Wheelchairs

- HHS/OIG compared Medicare payments for power wheelchairs with suppliers' acquisition costs and determined the number and type of services that suppliers performed in conjunction with providing power wheelchairs to Medicare beneficiaries. In the report, HHS/OIG found that in the first half of 2007, Medicare allowed an average of \$4,018 for standard power wheelchairs that cost suppliers an average of \$1,048. During the same timeframe, Medicare allowed an average of \$11,507 for complex rehabilitation packages that cost suppliers an average of \$5,880. Suppliers of standard power wheelchairs reported performing an average of five services per chair, while suppliers of complex rehabilitation power wheelchair packages reported performing an average of seven services, such as assembling and delivering the power wheelchair and educating the beneficiary about its use. In addition, suppliers performed most services prior to and during, rather than after, the wheelchairs' delivery. HHS/OIG recommended that CMS consider several methods to determine whether Medicare's fee schedule amounts for standard and complex rehabilitation power wheelchairs should be adjusted, including using information from the Competitive Bidding Program, seeking legislation to ensure that fee schedule amounts are reasonable and responsive to market changes, and/or exercising its authority to set payment limits when payments are grossly higher than acquisition costs.

Appeals by Suppliers with Revoked Billing Privileges

- HHS/OIG updated a March 2007 report on South Florida medical suppliers, focusing on the 491 suppliers that we identified during 1,581 unannounced visits as failing to meet Medicare

standards and that had their billing privileges revoked by CMS. Nearly half of them appealed the revocations and received hearings. At the time HHS/OIG issued the follow-up report in October 2008, of the 243 suppliers that appealed and received hearings, 91 percent had their billing privileges reinstated. HHS/OIG found that without criteria regarding the types of evidence necessary to reinstate the billing privileges of suppliers, hearing officers reinstated the suppliers' billing privileges based on a variety of evidence. Following a review of reinstated suppliers by CMS's contractor, two-thirds of the reinstated billing numbers were again revoked or inactivated, and some individuals connected to reinstated suppliers have been indicted. CMS agreed with the report's recommendation to strengthen the appeal process by developing criteria regarding the types of evidence required for hearing officers to reinstate suppliers' billing privileges.

Medicare Part D Pharmacy Reimbursement

- In a comparison of Part D and Medicaid pharmacy reimbursement for 40 single-source and 39 multiple-source drugs in the third and fourth quarters of 2006, HHS/OIG found that Part D and Medicaid pharmacy reimbursement amounts for most of the single-source drugs reviewed were similar. However, Medicaid reimbursement amounts for the multiple-source drugs reviewed were typically higher than the Part D amounts. For the five States selected for our review, HHS/OIG found that the Medicaid and Part D ingredient cost reimbursement amounts were similar for single-source drugs. In all five States, the average Medicaid ingredient costs exceeded the average Part D ingredient costs for most multiple-source drugs under review. In addition, Medicaid dispensing fees were substantially higher than average Part D dispensing fees for both the single-source and multiple-source drugs under review.

Medicare-Medicaid Dual Eligibles for Drug Benefits

- HHS/OIG found that New Jersey complied with certain provisions of the Medicare demonstration application when claiming drug costs for full-benefit dually eligible beneficiaries (fully eligible for both Medicare and Medicaid). The demonstration project permitted Medicare to reimburse States for full-benefit dually eligible beneficiaries' Part D drugs to the extent that the costs were not recoverable from a Medicare Part D plan. However, New Jersey claimed some drug and administrative costs to both the Medicaid program and the Medicare demonstration project. HHS/OIG found that the State did not adjust its Medicaid claims to reflect \$11.3 million (\$5.8 million Federal share) in costs already reimbursed under the Medicare demonstration project. HHS/OIG recommended that the State refund \$5.8 million to the Federal Government for improper Medicaid drug claim payments (\$5.2 million) and administrative cost payments (\$600,000).

Medicare Part D Fraud and Abuse Prevention

- HHS/OIG's review of Medicare stand-alone prescription drug plan sponsors' identification of potential fraud and abuse found that 24 of 86 sponsors had not identified any potential fraud and abuse incidents in the first six months of 2007. Stand-alone prescription drug plan

sponsors contract with CMS to provide Part D drug coverage to Medicare beneficiaries. Sponsors are required to have a comprehensive and effective program to detect and deter fraud. Potential fraud and abuse may be identified during internal claim reviews or through complaints or referrals from external sources, such as CMS, Medicare Drug Integrity Contractors (MEDIC), law enforcement agencies, beneficiaries, and pharmacy providers. HHS/OIG found that of the 62 sponsors that identified incidents, 7 accounted for 90 percent of all incidents identified, 47 conducted inquiries, 32 initiated corrective actions, and 33 referred incidents to other entities for further investigation. Overall, 17 plan sponsors initiated all three actions, 21 initiated two actions, 19 initiated one action, and 5 did not initiate any actions. Also, HHS/OIG found that the most prevalent type of potential fraud and abuse incident identified was inappropriate billing, such as claims submitted for drugs not provided. Recommendations included, among other things, that CMS review Part D plan sponsors to determine why certain sponsors identified especially high or low volumes of potential fraud and abuse; and determine whether the Part D plan sponsors that identified potential fraud and abuse initiated inquiries and corrective actions and made referrals for further investigation as recommended by CMS.

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 2009, the HHS/OIG, in consultation with DOJ, issued 27 advisory opinions. A total of 219 advisory opinions have been issued during the 13 years of the HCFAC program.
- Corporate and Other 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, Integrity Agreement or other similar agreement. 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 2009, HHS/OIG was monitoring compliance with 338 such agreements.

Centers for Medicare & Medicaid Services

In FY 2009, the Centers for Medicare & Medicaid Services (CMS) was allocated approximately \$25 million in HCFAC mandatory funds and approximately \$160 million in HCFAC discretionary funds to support 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.

Strengthened Program Integrity Activities in Medicare Advantage and Medicare Part D

CMS invested \$74 million in HCFAC discretionary funds to strengthen Medicare Parts C and D oversight. CMS conducted a comprehensive program assessment to reevaluate its contracting strategy, the structure of the Medicare Drug Integrity Contractors (MEDICs), and the manner in which it oversees fraud, waste, and abuse activities. CMS also added additional resources to: review plans' bids and ensure accurate payments, conduct on-going monitoring and plan performance assessments to ensure issues are spotted and responded to quickly to protect beneficiaries, ensure that plans are following clinical guidelines, and conduct additional compliance audits and related activities.

CMS has continued to devote HCFAC resources to the MEDICs to address new complexities facing law enforcement; contract and plan oversight functions; monitoring, plan performance assessment, and surveillance/secret shopper activities; audits of the program; and routine compliance and enforcement tracking.

The MEDICs are responsible for:

- Managing all incoming complaints about Part C and Part D Fraud, Waste, and Abuse (FWA),
- Utilizing new and innovative techniques to monitor and analyze information to help identify potential fraud,
- Working with law enforcement, Medicare Advantage and prescription drug plans, consumer groups and other key partners to protect consumers and enforce Medicare's rules,
- Providing basic tips for consumers so that they can protect themselves from potential scams, and
- Performing proactive research utilizing all available data to find trends in order to ferret out FWA activities.

Since their inception, the MEDICs' work has resulted in thousands of complaints being investigated and approximately 300 cases being referred to law enforcement. In 2009 alone the MEDICs referred 140 cases to Federal law enforcement and hundreds of cases have been referred to state insurance commissioners and enforcement agents.

Until last year, the MEDICs were responsible for performing program safeguard functions to detect and prevent fraud, waste, and abuse (FWA) and to mitigate vulnerabilities associated only with the Part D program. In 2009, with new HCFAC discretionary resources, CMS expanded the scope of the MEDICs by including Part C under their jurisdiction. Also, to promote more consistency geographically and to align better with the Zone Program Integrity Contractors (ZPICs), CMS restructured the MEDICs across the following business lines: compliance and benefit integrity. This change occurred in 2009 and will be effective with work performed in FY 2010.

Established Additional Regional Call Centers and Focused Beneficiary Outreach

South Florida Fraud Hot Line

As part of a two-year demonstration project, CMS established a special fraud hotline in 2007 to protect Medicare beneficiaries in South Florida from fraudulent providers of infusion therapy. As a result of the hotline's success, CMS expanded the scope of this infusion therapy fraud hotline to handle all Medicare fraud-related calls in South Florida. The fraud hotline number is being included on monthly Medicare Summary Notices (MSNs) sent to beneficiaries in Miami-Dade, Broward and Palm Beach counties.

There is now a rapid response team that investigates the highest priority leads received from the fraud hotline within two weeks of receipt of the call and then works with CMS and/or law enforcement to pursue appropriate follow up action. From August 2009 to December 31, 2009, there were 261 investigations from over 1,359 calls and over 311 activity checks. Additionally, 11 Medicare provider numbers were revoked, 3 bank accounts were frozen, and 26 providers were placed on pre-payment review. Furthermore, \$11 million has been requested in overpayments, there were 7 immediate advisements to OIG, and 3 referrals to law enforcement.

Increased Funding for Program Integrity Demonstrations / Special Initiatives

Durable Medical Equipment (DME) Stop Gap Plan

This plan was developed in response to the continued escalation in DME payments, the growth in the number of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers, and Congress' postponement of DMEPOS competitive bidding. This short-term plan enhanced DME fraud, waste and abuse detection and prevention activities in seven high risk States (California, Florida, Illinois, Michigan, North Carolina, New York and Texas) as well as the high risk suppliers, ordering physicians, DMEPOS items, and beneficiaries in each area. From September 2009 to December 2009, 265 suppliers had their supplier numbers revoked or deactivated and \$5.4 million in claims was denied due to edits or suspensions on over 2,571 providers, suppliers and beneficiaries as a result of this new project.

Miami High Risk Demonstrations

Home Health Project: Most Miami-Dade Home Health Agencies receive significant compensation as a result of outlier payments borne of excessive skilled nursing visits to diabetic beneficiaries. Skilled nurses purport to administer insulin to these patients, but field investigations indicate that some beneficiaries are not homebound and do not qualify for services. Beneficiaries are routinely coached to feign qualifying conditions. Home Health nurses, nurses, aides and ordering physicians are typically complicit in furtherance of the scam. This study was developed in response to the above issues resulting in the following: 32 suspensions and total edit saving of \$ 2,783.167.86.

Enrollment Special Study: The purpose of this Special study is to perform additional fraud, waste and abuse detection, deterrence and prevention activities. This is a collaboration between the MAC (First Coast Services) and the ZPIC (SGS), for currently enrolled and new Medicare

providers in South Florida (Dade/Broward/Palm Beach Counties).

SGS and FCSO has worked together to create a Fraud Level Indicator (FLI) which provides a threshold for each provider type that has submitted a Medicare enrollment (855) Form. FCSO scores each provider and for those which exceed the threshold for that provider type, FCSO refers these suspect providers to SGS to conduct an Onsite Inspection at that provider location.

SGS responds by sending a team of investigators and nurses to the provider's location to ensure that that provider is in compliance with Medicare rules and regulations as well as confirms and verifies that the information provided to CMS/FCSO in the application form is accurate.

The goal is to stop the fraudulent providers from obtaining new Medicare provider numbers, reduce the number of the habitual "bad providers" from re-entering the Medicare system after they have been kicked out in the past, and stop the pay and chase mentality that has existed in the PSC/ZPIC world in years past.

Increased Capacity to Identify and Prevent Excessive Payments

Automated Fraud Edits

CMS uses automated fraud edits to help prevent improper or fraudulent claims from being paid. For example, after a Medicare infusion scam that involved for-profit clinics and doctors recruiting HIV/AIDS patients, paying them kickbacks to come to their clinics to receive infusion services, and billing for those services at medically unbelievable frequencies and dosages, CMS implemented Medically Unbelievable Dosage Edits. With these edits, claims from providers who bill units of medication at lethal dosage amounts are auto denied. CMS has also implemented Beneficiary Autodenial Edits which deny claims for the top 200 Medicare high volume infusion beneficiaries.

Infusion Therapy Demonstration

CMS has also increased scrutiny of claims in areas of the country where infusion therapy has appeared vulnerable to fraudulent activities. CMS implemented an infusion therapy demonstration that ended in 2009. As a result of the initiatives in the demonstration, more than 28 providers were referred to law enforcement; 410 provider numbers were revoked; and more than \$254 million in savings resulted from edits leading to claims denials – with total cumulative savings and costs avoided under the demonstration topping \$485 million.

Targeted Focus

CMS is addressing Medicare "hot fraud" areas with ZPICs and the Program Integrity Field Offices (FOs). The ZPICs allow CMS the opportunity to allocate and adjust resources to focus on the highest risk fraudulent activities and geographic areas, particularly fraud, waste, and abuse "hot zones." Examples include targeted data analysis, site visits to provider locations, beneficiary interviews, and innovative support to law enforcement. The designated Program Integrity FOs in

Los Angeles, Miami and New York provide an on the ground presence focusing on high risk fraud areas of the country. They conduct data analysis to proactively identify targets and to coordinate efforts among various contractors and agencies to identify local, field level issues and vulnerabilities with national or regional impact.

The Miami FO has implemented a comprehensive, multipronged approach to address all aspects of healthcare fraud in South Florida and provides a testing ground for whether some of these efforts may eventually have efficacy on a national level. This initiative focuses on more intensive provider enrollment screening. CMS also implemented a fraud hotline, follow-up site visits, and prepay review for watch lists providers and suppliers under the South Florida strategy. In addition, CMS instituted a number of targeted efforts in high vulnerability areas such as Miami, Houston and Los Angeles where there are a large number of beneficiaries and providers/suppliers. CMS and its contractors are conducting special projects focusing on both high fraud provider/supplier types and high fraud areas of the country.

Medicare Secondary Payer Recovery Contractors

Additionally, Medicare Secondary Payer (MSP) Recovery Contractors were also partially funded through the use of discretionary HCFAC dollars. These contractors make sure recovery actions are undertaken when Medicare pays for claims where it did not have the primary responsibility to do so.

Enhanced Provider Oversight Efforts

In 2009 CMS invested \$14 million of the HCFAC discretionary funding in enhanced provider oversight activities. CMS has undertaken numerous aggressive actions to tighten the provider enrollment process through a systematic and risk-based application review before enrollment occurs by conducting onsite verifications and by requiring surety bonds.

Provider and supplier enrollment applications are now being evaluated and assigned a fraud score (high, medium or low) based on potential fraud risk to the program. In assessing a fraud level indicator, factors such as experience as a supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), experience with other payers, prior Medicare experience, and geographic area are being considered in assigning a fraud score. Applicants are given a more rigorous screening based on the fraud score. Those applicants with a high or medium fraud score receive at least one unannounced site visit to verify compliance with the supplier standards. DMEPOS suppliers that are not in compliance with one or more of the supplier standards will have their billing number revoked. The enhanced review of applications for new DMEPOS supplier billing numbers will prevent these providers from entering the program.

CMS has also implemented new DMEPOS Accreditation Standards which will ensure DMEPOS suppliers meet CMS' supplier certification standards. All DMEPOS suppliers must comply with the CMS quality standards in order to receive Medicare Part B payments and to retain a supplier billing number. A supplier billing number will not be issued to any non accredited supplier, thus any non-accredited supplier attempting to bill Medicare, will be automatically 'kicked-out' of the

system.

CMS has also established a surety bond requirement for all DMEPOS suppliers. Provider numbers cannot be issued or renewed unless the supplier obtains and maintains a surety bond on a continuous basis. The surety bond requirement for DMEPOS suppliers is expected to:

- Limit the Medicare program risk to fraudulent DMEPOS suppliers;
- Ensure that only legitimate DMEPOS suppliers are enrolled or are allowed to remain enrolled in the Medicare program;
- Provide Medicare with the time necessary to determine if a DMEPOS supplier is acting in good faith;
- Ensure that the Medicare program recoups erroneous payments from fraudulent or abusive billing practices by allowing CMS or its designated contractor to seek payments from a surety up to the penal sum; and
- Ensure that Medicare beneficiaries receive products and services that are considered reasonable and necessary from legitimate DMEPOS suppliers.

Combined, the impact of the surety bond and accreditation efforts is substantial. Since October 1, 2009, CMS has revoked over 10,000 suppliers as a result of failure to meet the more stringent enrollment criteria and another 6,000 suppliers have voluntarily withdrawn from the program rather than be held accountable to the new standards.

Measured Error Rate

Comprehensive Error Rate Testing (CERT)

CMS developed the Comprehensive Error Rate Testing (CERT) program to produce Medicare FFS national paid claim error rates specific to contractor, service type, and provider type. The program calls for independent reviewers to periodically review a systematic random sample of claims that are identified after they are accepted into the claims processing system at carriers, fiscal intermediaries, and MACs.

These sampled claims are then followed through the system to their final disposition. The independent reviewers medically review claims that contractors paid or denied to ensure that the payment decision was appropriate. The decisions of the independent reviewers are entered into a tracking database. Annual reports are produced that provide the basis for program planning, evaluation, and corrective actions.

During the 2009 report period, CMS significantly revised and improved the way that it calculates the Medicare FFS error rate based on recommendations from the Office of Inspector General – making its review requirements more stringent and in line with CMS policies and manuals. We will revise the baseline for the performance measure moving forward.

This program is funded normally from mandatory HCFAC allocations. However, as a result of the revised and improved method for calculating the error rate, CMS required an additional \$2.5 million from discretionary funding.

Payment Error Rate Measurement (PERM)

The PERM program was developed to comply with the requirements of the Improper Payments Information Act of 2002 (IPIA), which requires HHS to annually produce national level error rates for Medicaid and the Children's Health Insurance Program (CHIP). CMS elects to use Federal contractors to measure Medicaid and CHIP error rates in a subset of States every year. In FY 2006, CMS measured the fee-for-service component of Medicaid. Starting with FY 2007, PERM was expanded to measure error rates for fee-for-service, managed care, and eligibility in both the Medicaid and CHIP programs.

On November 16, 2009, CMS reported a two-year weighted average national error rate for Medicaid that included data from the FY 2007 and FY 2008 cycles. The two-year average national Medicaid error rate is 9.6 percent. The weighted national error component rates are: Medicaid fee-for-service: 5.7 percent; Medicaid managed care: 1.5 percent; and Medicaid eligibility: 4.9 percent. The error rate for the states that participated in the FY 2008 cycle is 8.7 percent, compared to 10.5 percent for states measured in FY 2007. Beginning next year, CMS will be reporting a baseline error rate for Medicaid and going forward the reported rate will be a "rolling average" of the most recent three years. States participating in the FY 2008 cycle were also provided with their individual error rates. Further evaluation of the error rates shows that the vast majority of Medicaid errors were due to cases reviewed for eligibility that were either not eligible or undetermined. Other errors occurred because providers either did not submit information to the PERM contractor to support their sampled fee-for-service claims or did not submit additional data as requested. CMS is currently measuring FY 2009 cycle states and has also commenced the FY 2010 cycle. CMS expects the error rates for Medicaid will decline in future years through program maturation and corrective action initiatives implemented at the State and Federal levels.

Section 601 of the *Children's Health Insurance Program Reauthorization Act* (CHIPRA) of 2009 (P.L. 111-3) prohibits CMS from calculating or publishing any national or State-specific error rates for CHIP until six months after a new PERM final rule is in effect. CMS is currently developing a final regulation as required by CHIPRA. Therefore, for the FY 2008 cycle, CMS did not report a national CHIP error rate.

Further Development of Near-Real Time Data Analysis Tool

The One Program Integrity (One PI) data project was developed to, for the first time, provide a fully integrated searchable database of all Medicare paid claims. One PI is the set of analytic tools which will eventually be used to perform data analysis across a centralized Integrated Data Repository (IDR) of standardized Medicaid data across multiple States along with data from Medicare Parts A, B, and D. The IDR currently houses National Claims History and Part D data dating back to January, 2006. The availability of a centralized source for accessing the tremendous volume of data on claims, providers, and beneficiaries will enable consistent, reliable,

and timely analyses. This will, in turn, improve the ability to detect fraud, waste, and abuse in the Medicare and Medicaid programs. CMS will continue to add additional data streams and reference data to the IDR. Eventually, One PI will house near real-time data.

Funded Medicaid/Children's Health Insurance Plan (CHIP) Financial Management Project

Under this project, funding specialists, including accountants and financial analysts, work to improve CMS' financial oversight of the Medicaid and CHIP programs. Through the continued efforts of these specialists, CMS identified and resolved \$3.5 billion of approximately \$7 billion in cumulative questionable costs in FY 2009. Furthermore, an estimated \$1.5 billion in questionable reimbursement was actually averted due to the funding specialists' preventive work with states to promote proper state Medicaid financing. The funding specialists' activities include reviews of proposed Medicaid state plan amendments that relate to reimbursement; development of financial management reviews; research regarding state Medicaid financing policy and practices; collaboration with states to resolve the Medicaid and CHIP portions of the A-133 "Single State" audits; and identification of sources of the non-Federal share of Medicaid program payments to ensure proper financing of Medicaid program costs.

Administration on Aging

In FY 2009, the Administration on Aging (AoA) was allocated \$3.2 million in HCFAC funds to develop and disseminate consumer education information targeted to older Americans, with a particular focus on persons with low health literacy, individuals from culturally diverse backgrounds, persons living in rural areas, and other vulnerable populations. AoA and its nationwide network of agencies 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.

The \$3.2 million in HCFAC dollars specifically support infrastructure, technical assistance and the other Senior Medicare Patrol (SMP) program support and capacity-building activities designed to enhance the effectiveness of state-wide SMP programs which are funded from a separate Congressional appropriation. These SMP programs recruit 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 most recent annual performance report from the Assistant Inspector General for Evaluation and Inspections dated May 18, 2009, 4,685 active volunteers served the 54 SMP projects during 2008. These volunteers performed an essential function of this program, contributing close to 113,000 hours in efforts to share the SMP message of fraud awareness and prevention within the senior community.

Outreach to senior consumers is a key element of the SMP program. During 2008, SMP projects held over 5,700 community education events reaching over an estimated 1.5 million people, and conducted over 785,000 media outreach activities to increase beneficiary awareness about issues related to Medicare and Medicaid integrity. During this period, over 24,500 one-on-one counseling sessions were held with or on behalf of a beneficiary on a variety of issues related to

potential Medicare or Medicaid fraud, error or abuse. In addition, over 308,700 beneficiaries were educated through close to 7,000 group educational sessions conducted by SMP programs in local communities.

As a result of educating beneficiaries, the projects received over 40,000 inquiries in 2008 from or on behalf of beneficiaries and resolved over 99 percent of the inquiries during this period. In addition, SMP projects received over 4,000 complex issues—i.e., beneficiary complaints requiring further research, assistance, case development and/or referral—as a result of educational efforts. While the SMP program staff was able to resolve over 2,700 of these complaints for beneficiaries, over 440 of these issues, with an estimated dollar value of over \$2.34 million, were referred to law enforcement, CMS integrity contractors, state Medicaid Fraud Control Units, or other entities for further action. During this period, the OIG documented that over \$73,000 in healthcare expenditures were avoided and over \$65,000 in Medicare, Medicaid and other savings resulted from actions taken by the SMP program.

Since the program's inception, SMP projects have educated close to 3.6 million beneficiaries and received over 108,000 complex issues (complaints) from beneficiaries who have detected billing or other discrepancies based on that information. 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 \$105.72 million has been reported as savings attributable to the program as a result of documented complaints since its inception in 1997.

Office of the General Counsel

In FY 2009, the Office of the General Counsel (OGC) was allocated \$5.714 million in HCFAC funding to supplement OGC's efforts to support program integrity activities. OGC's efforts in FY 2009 focused heavily on program integrity review, in which OGC reviews CMS' programs and activities in order to strengthen them against potential fraud, waste, and abuse. OGC also continued to expand its litigation role in order to assist in the recovery of program funds. During FY 2009, OGC was involved in a wide range of matters that resulted in approximately \$2.6 billion in judgments, settlements, or other types of recoveries, savings, or receivables described elsewhere in this report.

HEAT: During FY 2009, OGC became involved in the Health Care Fraud Prevention and Enforcement Action Team (HEAT), the newly-formed joint DOJ-HHS anti-fraud initiative. OGC has worked closely with other HEAT members to combat fraud, waste and abuse in the Medicare and Medicaid programs by providing advice on the myriad legal issues presented as the Government works to initiate innovative anti-fraud programs in various hotspots throughout the country. OGC's involvement in HEAT includes advising CMS on provider and supplier revocations, payment suspensions and recoupments that arise from the initiative (in addition to criminal and civil fraud prosecutions) and defending the administrative appeals that may result. OGC will continue to assist DOJ in prosecuting those seeking to defraud Medicare and Medicaid and to defend any Federal court challenges that are brought as a result of this initiative.

False Claims Act (FCA) and Qui Tam Actions: OGC assists DOJ in assessing *qui tam* actions filed under the FCA by interpreting complex Medicare and Medicaid rules and policies in order to help DOJ focus on those matters which are most likely to result in a recovery of money for the Government. When DOJ files or intervenes in a FCA matter, OGC provides litigation support, including interviewing and preparing witnesses and responding to requests for documents and information. In FY 2009, OGC participated in FCA and related matters that recovered over \$2.3 billion for the Medicare and Medicaid programs.¹² The types of FCA cases in which OGC participated include: drug pricing manipulation; illegal marketing activity by pharmaceutical manufacturers that resulted in Medicare and Medicaid paying for drugs for indications that were not covered; underpayment of rebates to state Medicaid programs; physician self-referral and Anti-Kickback Act violations; provider upcoding and outlier cases; and sales of faulty diagnostic test kits. OGC has also been assisting DOJ in an emerging workload of cases involving alleged fraud in Medicare Part D, the voluntary Medicare prescription drug program.

Provider/Supplier Suspensions and Enrollment Revocations or Denials: Suspensions play a critical role in protecting the abuse of program funds because they prevent possible fraudulent payments, avoiding the need to “chase” down these funds later. They also provide a source from which CMS can obtain recoupment after a final overpayment has been determined. OGC advises CMS on whether to suspend payments to Medicare providers and suppliers and defends the suspensions if challenged. During FY 2009, OGC attorneys were involved in over 700 suspension and recoupment actions, totaling over \$21 million, many of which involved fraudulent billings and different segments of the health care industry, including DME suppliers, ambulance companies, physicians, infusion clinics, therapists, home health agencies, and diagnostic testing facilities. OGC also represents CMS when a provider or supplier appeals CMS’ denial of enrollment or revocation. During FY 2009, OGC represented CMS in over 250 appeals before the Departmental Appeals Board (DAB) and typically resolved these cases without formal hearings. OGC also continued to advise CMS on the interpretation of enrollment regulations and reviewed proposed enrollment rules and manual changes.

Medicare Prescription Drug Program (Part D) & Medicare Advantage Program (Part C) Compliance: OGC continues to provide extensive advice to CMS on a variety of Part D and Medicare Advantage-related contract compliance issues, including identifying enforcement options against sponsors that are noncompliant or violate program rules, such as Marketing Guidelines. OGC reviewed compliance-related correspondence that CMS issued to Part D sponsors and MA plans in the form of warning letters, corrective action plan letters, intermediate sanction and CMP notices and non-renewal or termination notices.

Civil Monetary Penalties (CMPs): CMS has the responsibility for administering numerous civil monetary penalty provisions enacted by Congress to combat fraud, waste, and abuse by enforcing program compliance and payment integrity. During FY 2009, OGC provided legal advice to CMS

¹² This figure includes the \$668 million Federal share of the Government’s FCA settlement with Pfizer Inc to resolve allegations of off-label promotion of several drugs for indications which were not covered by Federal health care programs. This amount will not be officially reported until FY2010.

regarding the development and imposition of CMPs and defended CMS in over 1200 administrative appeals and judicial litigation resulting from these cases, recovering or establishing the right to recover over \$20.6 million in CMPs.

Petitions for Remission: OGC regularly collaborates with Federal law enforcement, including the FBI, the U.S. Attorneys' Offices, the Secret Service, U.S. Postal Service, and the U.S. Marshal's Service in filing petitions for remission directed to recover assets subject either to administrative forfeiture by Federal law enforcement or civil judicial forfeiture by DOJ. Each petition sets forth the background of the fraudulent scheme, the history of Medicare's payments, and how the fraudulently induced payments could be traced to the seized assets. During FY 2009, OGC petitioned these agencies to recover funds in both criminal and civil litigation matters in which Medicare was a victim of fraud involving about \$4.6 million seized by law enforcement agencies.

Regulatory Review and Programmatic Advice: During FY 2009, OGC advised CMS on regulations and provided programmatic advice related to a wide range of program integrity issues, including the following: compliance and appeals for the Medicare Advantage and Part D programs; payment safeguards for home health agencies (HHAs); home health fraud initiatives, particularly the South Florida initiative focused on reviewing and suspending HHAs that are suspected of fraudulent billing; appeals processes and sanctions for PACE organizations; and appeals procedures for the Retiree Drug Subsidy.

Medicaid Integrity: OGC saw increased involvement in FY 2009 in Medicaid integrity issues as CMS devoted more resources to financial reviews and oversight and as States continued to present innovative proposals to reconfigure their programs and to draw down Federal financial participation (FFP) at or beyond the margins of the regular Medicaid program. OGC also saw a significant increase in the provision of legal advice to CMS regarding proposed disallowances, many resulting from increased audit scrutiny of state Medicaid expenditures and the filing of Medicaid disallowance appeals before HHS' DAB. In FY 2009, OGC saw an increase in disallowances taken in instances where a State received a settlement, often from a pharmaceutical manufacturer, under its State false claims act law or a State consumer protection or fraud law and did not properly pay the Federal Government its fair share of the recovery. During 2009, OGC was successful in securing over \$82 million in Medicaid program savings.

Physician Self-Referral: OGC provides valuable assistance to CMS in navigating the complexities of the Stark physician self-referral law. In FY 2009, OGC reviewed and offered extensive comments on new Stark regulations and their implementation, successfully defended two regulatory challenges to controversial new provisions in the Stark law and anti-markup rules, and reviewed several draft Stark advisory opinions. In addition, OGC has reviewed various payment or coverage rules and suggested modifications necessary to avoid implicating, or to conform the regulation to, the Stark law.

Medicare Secondary Payer (MSP) Workload: OGC's efforts to recover conditional payments by Medicare that are the primary responsibility of other payers directly supports the HCFAC statutory goal of facilitating the enforcement of all applicable legal remedies for program fraud and abuse. During FY 2009, OGC has been successful in establishing the right to recover \$37 million for

Medicare under the MSP program. Recent statutory changes to the MSP law have strengthened and expanded OGC's efforts in this area – to the benefit of the Medicare Trust Fund – including substantial CMPs for failure to report.

Bankruptcy Litigation: OGC protects Medicare funds when providers seek bankruptcy protections by asserting CMS' recoupment rights to collect overpayments, arguing to continue suspension or termination actions against debtors, seeking adequate assurances from the bankruptcy court that CMS' interests in the debtor's estate will be protected, arguing for the assumption of the Medicare provider agreement as an executory contract, and petitioning for administrative costs where appropriate. In 2009, OGC vigorously asserted CMS' interests in numerous bankruptcy and receivership actions involving hospitals, nursing homes and nursing home chains, negotiated agreements to recover overpayments, and aggressively advanced the use of Medicare's recoupment authority, collecting or establishing the right to collect over \$36 million in overpayments involving bankrupt providers.

Denial of Claims and Payments: CMS and its contractors engage in various activities and initiatives to detect and prevent abusive and fraudulent billing practices. These measures may include provider and beneficiary education, use of claim sampling techniques and a more rigorous scrutiny of claims with increased medical review. In FY 2009, OGC played a major role in advising CMS regarding the development and implementation of these types of program integrity measures and defended CMS in litigation brought by providers and suppliers who challenge these efforts. OGC continues to aggressively defend CMS and its contractors in cases seeking damages for the alleged wrongful denial of claims, for being placed on payment suspension and for not being granted extended repayment plans.

THE DEPARTMENT OF JUSTICE

United States Attorneys

In FY 2009, the United States Attorneys' Offices (USAOs) were allocated approximately \$42.8 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 district resources to combating health care fraud and abuse in 2009, 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 and criminal health care fraud referrals are often made to USAOs through the law enforcement network described herein, and these cases are usually handled primarily by the USAOs, although civil cases 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 solely by the USAO. USAOs also handle most criminal and civil appeals at the Federal appellate level.

In addition to the positions funded by HCFAC, the Executive Office for United States Attorneys' Office of Legal Education (OLE) 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 2009, OLE offered a Health Care Fraud Seminar for AUSAs and DOJ attorneys, which was attended by over 100 attorneys, as well as a Medicare Fraud Strike Force Seminar, and an Affirmative Civil Enforcement Conference, including health care fraud issues, for paralegals, auditors and investigators.

Criminal Prosecutions

In FY 2009, the USAOs received 1,014 new criminal matters involving 1,786 defendants, and had 1,621 health care fraud criminal matters pending,¹³ involving 2,706 defendants. The USAOs filed criminal charges in 481 cases involving 803 defendants, and obtained 583 Federal health care fraud related convictions.

Civil Matters and Cases

¹³When 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.

USAOs play a major role in health care fraud enforcement by bringing affirmative civil cases to recover funds wrongfully taken from the Medicare Trust Fund and other taxpayer-funded health care systems as a result of fraud, waste, and abuse. 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, overcharges by hospitals, Medicaid fraud, and kickbacks to induce referrals of Medicare or Medicaid patients, fraud by pharmaceutical companies, and failure of care allegations against nursing home owners.

In FY 2009, DOJ opened 886 new civil health care fraud investigations. At the end of FY 2009, the USAOs had 1,155 civil health care fraud investigations pending.

Civil Division

In FY 2009, the Civil Division was allocated approximately \$24.3 million in HCFAC funding to support civil health care fraud litigation (this amount includes \$1 million allotted for the Elder Justice and Nursing Home Initiative). Civil Division attorneys pursue civil remedies in health care fraud matters, working closely with the USAOs, the HHS/OIG, the FBI, the Department of Defense, 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 (FEHBP), and other Government health care programs.

Civil Division attorneys investigate and litigate a wide range of health care fraud matters. These matters include allegations that Medicare and Medicaid providers and suppliers (e.g., hospitals, doctors, skilled nursing facilities, pharmaceutical and device manufacturers) overcharged the Government for health care services or goods, or, that they billed for goods and services that were either not provided or not medically necessary. Oftentimes, these allegations are linked to allegations that the doctors and others were 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. The Civil Division also actively investigates a wide range of pharmaceutical and device fraud, including allegations of drug price manipulation and illegal marketing activity that caused the Medicare and Medicaid programs to pay for drug uses that either were neither approved by the FDA nor supported by medical literature.

In addition to its recovery efforts, the Civil Division remains active in providing training and guidance in connection with pharmaceutical and device fraud matters. Given the nationwide scope of the defendants' conduct, as well as the complex legal and factual issues raised in these cases, the Civil Division plays a critical role in coordinating both investigative efforts and the legal positions taken by the Department. Likewise, because of that central coordinating role, the Civil Division has taken a leadership role in the HEAT Pharma subcommittee.

Lastly, the Elder Justice and Nursing Home Initiative, which is housed within the Civil Division, continues to coordinate and support law enforcement efforts to combat elder abuse, neglect, and

financial exploitation. The Initiative supports law enforcement efforts by maintaining an information bank of Elder Justice related materials (including briefs, opinions, indictments, plea agreements, subpoenas templates); funding medical reviewers, auditors, and other consultants to assist DOJ attorneys and AUSAs in their nursing home and/or long term care facility cases; hosting quarterly teleconferences with DOJ attorneys and AUSAs across the country to discuss issues or developments in connection with our nursing home and failure of care cases; and coordinating nationwide investigations of skilled nursing facilities. In addition to supporting law enforcement efforts, the Initiative continues to fund research projects awarded by the Office of Justice Programs, National Institute of Justice, to study the abuse, neglect and exploitation of elderly individuals and residents of residential care facilities.

Criminal Division

In FY 2009, the Criminal Division was allocated \$5.38 million in HCFAC funding to support criminal health care fraud litigation and interagency coordination, which is carried out primarily by two sections with the Criminal Division: the Fraud Section and the Organized Crime and Racketeering Section (OCRS).

The Fraud Section

The Fraud Section initiates and coordinates complex health care fraud prosecutions and supports the USAOs with legal and investigative guidance and training, and trial attorneys to prosecute health care fraud cases. Beginning in March 2007, the Criminal Division's Fraud Section working with the local U.S. Attorney's Offices, the FBI and law enforcement partners in HHS, and state and local law enforcement agencies launched the Medicare Fraud Strike Force in Miami-Dade County, Florida, to prosecute individuals and entities that do not provide legitimate health care services, but exist solely for the purpose of defrauding Medicare and other Government health care programs. Since 2007, DOJ and HHS have expanded the Strike Force by rolling out a second phase in the Los Angeles metro area in March 2008, a third phase in the Detroit metro area in June 2009, a fourth phase in the Houston metro area in July 2009. In FY 2009, the Fraud Section continued to provide attorney staffing, litigation support and leadership and management oversight of Strike Force prosecutions in each of the four cities. A summary of the Fraud Section's key litigation accomplishments in FY 2009 follow:

- Opened or filed 26 new health care fraud cases involving charges against 129 defendants who collectively billed the Medicare and Medicaid programs more than \$132 million;
- Obtained 43 guilty pleas and litigated four jury trials, winning guilty verdicts against nine defendants on all counts charged.¹⁴
- Prison sentences imposed in the Section's health care fraud cases during the year averaged more than 66 months, including one sentence of 30 years of imprisonment; and

¹⁴ Fraud Section attorneys litigated four Medicare Fraud Strike Force trials, two in the Central District of California and the other two in Southern District of Florida, which were summarized previously in the "Medicare Fraud Strike Force" section of this report.

- Court-ordered restitution, forfeiture and fines which exceeded \$113 million.

Fraud Section attorneys staffed and coordinated most of the Division's health care fraud litigation through the existing Medicare Fraud Strike Force prosecution teams in Miami and Los Angeles, and by implementing the third and fourth Strike Force phases during FY 2009.

Fraud Section attorneys, working with Federal prosecutors from the U.S. Attorneys Office for the Eastern District of Michigan, and Federal agents from the FBI and the HHS-OIG, presented evidence to a Federal grand jury sitting in Detroit, prepared seven indictments, and oversaw the execution of arrest warrants in Detroit, Miami, and Denver in connection with phase three of the Medicare Fraud Strike Force in the Detroit metropolitan area. On June 24, 2009, charges were unsealed against 53 individuals who were accused of various Medicare fraud offenses, including conspiracy to defraud the Medicare program, criminal false claims and violations of the anti-kickback statutes in schemes involving fraudulent infusion therapy and physical/occupational therapy providers. Collectively, the physicians, medical assistants, patients, company owners and executives charged in the indictments are accused of conspiring to submit more than \$50 million in false claims to the Medicare program. Since the phase three arrest round up in June 2009, Fraud Section attorneys have negotiated 17 guilty pleas in Detroit Strike Force cases as of September 30, 2009.

Fraud Section attorneys, working with Federal prosecutors from the U.S. Attorneys Office for the Southern District of Texas, Federal agents from the FBI, HHS-OIG, the Drug Enforcement Administration (DEA), the Offices of Inspector General for the Office of Personnel Management (OPM-OIG) and Railroad Retirement Board (RRB-OIG), and the Texas Attorney General's Medicaid Fraud Control Unit (MFCU), presented evidence to a Federal grand jury sitting in Houston, prepared seven indictments and 12 search warrants, and oversaw the execution of arrest warrants in Houston, New York, Boston and Louisiana in connection with phase four of the Medicare Fraud Strike Force in Houston. On July 29, 2009, charges were unsealed against 32 individuals who were accused of various Medicare fraud offenses, including conspiracy to defraud the Medicare program, and criminal false claims in schemes related to false billing for "arthritis kits," which were comprised of orthotic braces and heat pads, power wheelchairs and enteral feeding supplies. In some cases, indictments alleged that beneficiaries were deceased at the time they allegedly received the items. Collectively, the physicians, company owners and executives charged in the indictments are accused of conspiring to submit more than \$16 million in false claims to the Medicare program and \$5.9 million in false claims to the Texas Medicaid program.

In addition to health care fraud litigation, the Fraud Section also provided legal guidance to FBI and HHS agents, health program agency staff, AUSAs and other Criminal Division attorneys on criminal, civil and administrative tools to combat health care fraud; provided advice and written materials on patient medical record confidentiality and disclosure issues, and coordinated referrals of possible criminal HIPAA privacy violations from the HHS Office for Civil Rights; monitored and coordinated DOJ responses to legislative proposals, major regulatory initiatives, and enforcement policy matters; reviewed and commented on health care provider requests to the HHS/OIG for advisory opinions, and consulted with the HHS/OIG on draft advisory opinions;

worked with CMS to improve Medicare contractors' fraud detection, referrals to law enforcement for investigation, and case development work; and prepared and distributed to all USAOs and FBI field office periodic summaries of recent and significant health care fraud cases.

The Organized Crime and Racketeering Section (OCRS)

The Criminal Division's Organized Crime and Racketeering Section (OCRS) supports investigations and prosecutions of fraud and abuse targeting the 2.8 million private sector health plans sponsored by employers and/or unions, including schemes by corrupt entities that sell insurance products. Such private sector group health plans are the leading source of health care coverage for individuals not covered by Medicare or Medicaid. OCRS also provides strategic coordination in the identification and prosecution of domestic and international organized crime groups engaged in sophisticated frauds posing a threat to the health care industry.

OCRS provides litigation support and guidance to AUSAs and criminal investigative agencies to combat corruption and abuse of employment based group health plans covered by the Employee Retirement Income Security Act [ERISA]. For example, one OCRS attorney provided substantial litigation support in the prosecution of a scheme to deprive private sector workers on Federal and state construction projects in New York of their health and other employment benefits guaranteed under prevailing wage laws. OCRS attorneys provide health care fraud and abuse training and legal guidance to AUSAs and to criminal investigators and agents of the Department of Labor's Employee Benefits Security Administration and Office of Inspector General. The Section drafts and coordinates criminal legislative initiatives affecting employee health benefit plans and reviews and comments on legislative proposals affecting employment based health benefit plans.

OCRS attorneys also provide health care fraud and abuse training and legal guidance to AUSAs and to criminal investigators and agents of the Department of Labor's Employee Benefits Security Administration and Office of Inspector General. The Section drafts and coordinates criminal legislative initiatives affecting employee health benefit plans and reviews and comments on legislative proposals affecting employment based health benefit plans.

The OCRS attorneys also supported both the Medicare Fraud Strike Force and the Organized Crime Strike Force Units located within various United States Attorneys' Offices. For example, one OCRS attorney participated in the Los Angeles Medicare Fraud Strike Force investigating health care frauds perpetrated by organized criminal groups. OCRS attorneys also supported an Organized Crime Strike Force investigation in Florida involving a scheme to defraud Medicare by La Casa Nostra associates of the Bonano family. In that case, the targets submitted more than a million dollars in false claims to Medicare. Under the International Organized Crime Initiative commenced in 2009, OCRS monitors trends in the targeting of health care by international organized criminal groups.

Civil Rights Division

In FY 2009, the Civil Rights Division was allocated approximately \$2.4 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 2009 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 20 health care facilities in 14 states during Fiscal Year 2009. 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 2009, the Section opened or continued formal investigations, entered remedial agreements, or monitored existing remedial agreements regarding 80 health care facilities in 22 states, the District of Columbia, the Territory of Guam, and the Commonwealth of Puerto Rico.

The Section found that conditions and practices at three state facilities for persons with mental illness, twelve state facilities for persons with intellectual and developmental disabilities, and one nursing home violate the residents' Federal constitutional and statutory rights. Those facilities are: Northwest Georgia Regional Hospital, in Rome, Georgia; Kings County Hospital Center, in Brooklyn, New York; Ancora Psychiatric Hospital, in Winslow, New Jersey; Denton State Supported Living Center, in Denton, Texas; Abilene State Supported Living Center, in Abilene, Texas; Austin State Supported Living Center in Austin, Texas; Brenham State Supported Living Center, in Brenham, Texas; Corpus Christi State Supported Living Center, in Corpus Christi, Texas; El Paso State Center, in El Paso, Texas; Lufkin State Supported Living Center, in Lufkin, Texas; Mexia State Supported Living Center, in Mexia, Texas; Richmond State Supported Living Center, in Richmond, Texas; Rio Grande State Center, in Harlingen, Texas; San Angelo State Supported Living Center, in Carlsbad, Texas; San Antonio State Supported Living Center, in San Antonio, Texas; and William F. Green State Veterans Home, in Bay Minette, Alabama. In Fiscal

Year 2009, the Section commenced investigations of one county-operated nursing home, Maple Lawn Nursing Home in Palmyra, Missouri.

The Section entered settlement agreements to resolve its investigations of eight state operated facilities for persons with mental illness, thirteen state-operated facilities for persons with intellectual and developmental disabilities, and three state-operated nursing homes. Those facilities are: Georgia Regional Hospital in Atlanta, Georgia; Georgia Regional Hospital, in Savannah, Georgia; Northwest Georgia Regional Hospital, in Rome, Georgia; Central State Hospital, in Milledgeville, Georgia; Southwest State Hospital, in Thomasville, Georgia; West Central Georgia Hospital, in Columbus, Georgia; East Central Georgia Regional Hospital, in Augusta, Georgia; Connecticut Valley Hospital, in Middletown, Connecticut; Lubbock State Supported Living Center, in Lubbock, Texas; Denton State Supported Living Center, in Denton, Texas; Abilene State Supported Living Center, in Abilene, Texas; Austin State Supported Living Center in Austin, Texas; Brenham State Supported Living Center, in Brenham, Texas; Corpus Christi State Supported Living Center, in Corpus Christi, Texas; El Paso State Center, in El Paso, Texas; Lufkin State Supported Living Center, in Lufkin, Texas; Mexia State Supported Living Center, in Mexia, Texas; Richmond State Supported Living Center, in Richmond, Texas; Rio Grande State Center, in Harlingen, Texas; San Angelo State Supported Living Center, in Carlsbad, Texas; San Antonio State Supported Living Center, in San Antonio, Texas; C.M. Tucker Nursing Care Center, in Columbia, South Carolina; and Tennessee State Veterans' Homes in Murfreesboro and Humboldt, Tennessee.

In addition, the Section filed a contested complaint in United States v. Arkansas (E.D. Ark.) regarding conditions at Conway Human Development Center, in Conway, Arkansas.

The Section continued its investigations of nine residential facilities for persons with intellectual and 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 Bremerton, Washington; Bellefontaine Developmental Center, in St. Louis, Missouri; Northwest Habilitation Center, in St. Louis, Missouri; Clyde L. Choate Developmental Center, in Anna, Illinois; and Howe Developmental Center, in Tinley Park, Illinois. The Division also continued its investigation of Oregon State Hospital, in Salem, Oregon, a facility for persons with mental illness. In some of these matters, the Section is reviewing voluntary compliance to improve conditions.

The Section monitored the implementation of remedial agreements for 11 facilities for persons with intellectual and developmental disabilities: 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; Glenwood Resource Center, in Glenwood, Iowa; Woodbridge Developmental Center in Woodbridge, New Jersey; Oakwood Community Center in Somerset, Kentucky; and Beatrice State Developmental

Center, in Beatrice, Nebraska. It also monitored the implementation of remedial agreements regarding community placements from facilities for persons with intellectual and developmental disabilities in Indiana, Puerto Rico, and Washington, D.C.

The Section monitored the implementation of remedial agreements for four nursing homes: Reginald P. White Nursing Facility, in Meridian, Mississippi; Mercer County Geriatric Center, in Trenton, New Jersey; Ft. Bayard Medical Center and Nursing Home, in Ft. Bayard, New Mexico; and Laguna Honda Hospital and Rehabilitation Center, in San Francisco, California. The Section also monitored the implementation of remedial agreements regarding 11 state-operated residential facilities for persons with mental illness: Guam Mental Health Unit in the Territory of Guam; 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; Patton State Hospital, in Patton, California; and, St. Elizabeths Hospital, Washington, D.C.

APPENDIX

Federal Bureau of Investigation Mandatory Funding

In FY 2009, the FBI was allocated \$126.3 million in HCFAC funds for health care fraud enforcement. This yearly appropriation is used to support 769 positions (460 Agent, 309 Support). The number of pending investigations has shown steady increase from 591 pending cases in 1992 to 2,459 cases through 2009. FBI-led investigations resulted in 555 criminal health care fraud convictions and 844 indictments and informations being filed in FY 2009.

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 pro-actively 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, durable medical equipment companies and other health care facilities. The FBI is committed to addressing this criminal activity through disruption, dismantlement and prosecution of criminal organizations.

During FY 2009, the FBI entered the beginning stages of setting forth a Home Health Care Fraud Initiative. The overall goal of the Home Health Care Fraud Initiative is to identify fraudulent providers and target physicians who are willing to exploit the system for financial gain. The initiative will utilize data analysis, coupled with other investigative techniques and strategies to identify and target perpetrators of fraud involving the home health care.

During FY 2009 the FBI continued its support of the Miami Medicare Strike Force which was

established to combat prodigious Medicare fraud problem endemic to that particular geographic area. Its mission was to adapt the traditional investigative and prosecutorial methodology to more appropriately address the contemporary way in which Medicare fraud is committed. The Strike Force was a concerted effort from the Department of Justice, the United States Attorney's Office in the Southern District of Florida, the FBI, HHS/OIG, the Florida Medicaid Fraud Control Unit, and the Hialeah Police Department.

In addition in FY 2009 the FBI fully supported the DOJ led Medicare Strike Forces (MSF) in Los Angeles. The task force in Los Angeles is similar in composition to the Miami Medicare Strike Force with contributing agencies being the United States Attorney's office, Central District of California, the Internal Revenue Service - Criminal Investigative, HHS/OIG, the Los Angeles Police Department and other state and local agencies.

In FY 2009, the FBI also supported the expansion of the MSF concept to the Detroit and Houston field offices. The MSF in Detroit and in Houston are made up of the same types of Federal, State and Local agencies as detailed above in the Miami and Los Angeles strike forces.

The FBI has also initiated a new and aggressive training program. The FBI realizes that the most important resource for the successful investigation of health care fraud violations is that of human capital. Therefore, in FY 2009, as in FY 2008 and continuing the FBI will continue its aggressive training curriculum to include expanding the ability of those who investigate health care fraud matters to attend additional training sponsored by private entities such as the NHCAA.

The majority of funding received by the FBI is used to pay personnel costs associated with the 769 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 Internet Pharmacy fraud, Training and the DOJ Strike Force. Further, the FBI continues to support individual investigative needs such as the purchase of specialized equipment and expert witness testimony on an as-needed basis.

Glossary of Terms

The Account - The Health Care Fraud and Abuse Control Account

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

AUSA - Assistant United States Attorney

CERT - Comprehensive Error Rate Testing

CIA - Corporate Integrity Agreement

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

DAB-Department of Health and Human Services, Departmental Appeals Board

DEA - Drug Enforcement Administration

DME - Durable Medical Equipment

DMEPOS - durable medical equipment, prosthetics, orthotics, and supplies

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

FFP - Federal Financial Participation

FTE-Full-time equivalent

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

HHS - The Department of Health and Human Services

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

HI - Hospital Insurance Trust Fund

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

HIV - Human Immunodeficiency Virus

IPIA - Improper Payments Information Act of 2002, P.L. 107-300

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

MA - Medicare Advantage plan

MFSF - Medicare Fraud Strike Force

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

NHCAA - National Health Care Anti-Fraud Association

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

PERM - Program Error Rate Measurement

The Program - The Health Care Fraud and Abuse Control Program

CHIP - State Children's Health Insurance Plan

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

SMP - Senior Medicare Patrol

USAO - United States Attorney's Office