

THE 2009 HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM REPORT TO CONGRESS – AN OVERVIEW

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), acting through the Inspector General, designed to coordinate federal, state and local law enforcement activities with respect to health care fraud and abuse. Now in its fourteenth year, the HCFAC program has grown to new heights and accomplished much in the last year in our joint efforts.

2009 HCFAC REPORT HIGHLIGHTS

Turning up the HEAT on health care fraud

HCFAC now supports the Health Care Fraud Prevention and Enforcement Action Team or HEAT, the joint initiative between DOJ and HHS created to marshal the combined resources of both agencies in new ways to combat all facets of the health care fraud problem.

On the criminal enforcement side, HEAT has expanded Medicare Fraud Strike Force teams, which are joint operations between DOJ, HHS and state and local partners, to seven communities where evidence shows health care fraud is occurring at aberrant levels - places like South Florida; Los Angeles; Houston; Detroit; Brooklyn, N.Y.; Baton Rouge, La.; and Tampa, Fla. HEAT's civil enforcement activities include DOJ and HHS' investigatory and prosecutorial efforts against health care manufacturers, such as pharmaceutical companies. Through HEAT, the Obama Administration has taken an innovative approach by raising this important issue to the highest levels of both departments and by combining law enforcement and prevention efforts in one initiative. *We are prosecuting more people, returning more stolen money to the taxpayers while also working to prevent more losses at the front end.*

- During Fiscal Year (FY) 2009, 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.
- Deposits to the Medicare Trust Fund totaled approximately \$2.51 billion in FY 2009 as a result of these efforts, a \$569 million, or 29 percent, increase over FY 2008.
- In addition, more than \$441 million in federal Medicaid money was transferred separately to the U.S. Treasury - 28 percent more than in FY 2008.
- The HCFAC account has returned more than \$15.6 billion to the Medicare Trust Fund since its inception in 1997. During the past 3 years (2006-2009), the return-on-investment from the HCFAC law enforcement activities that form the primary focus

of this annual report has averaged approximately \$4 returned to the Trust Fund for every \$1 of HCFAC funding provided for enforcement activities.

New criminal and civil fraud investigations opened in 2009

In FY 2009, U.S. Attorneys' Offices and the Criminal Division's Fraud Section opened 1,014 new criminal health care fraud investigations involving 1,786 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.

HEAT Strike Force is a powerful weapon in the fight against fraud

According to the Report, FY 2009 Strike Force accomplishments in the four cities where Strike Force teams were deployed during the year include:

- 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 defendants; and
- 77 defendants imprisoned, averaging 46 months of incarceration.

Also, from their inception in 2007 through the end of FY 2009, Strike Force teams filed 244 cases charging 456 defendants who collectively billed Medicare \$900 million; 230 defendants pleaded guilty, 22 others were convicted in jury trials and 188 defendants were sentenced to prison.

Important Changes Made to Government Programs to Stop Fraud and Save Taxpayer Dollars

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 – \$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, online at <http://oig.hhs.gov/reading/semiannual.html>.

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).

Important Investments in Prevention to Strengthen Program Integrity

The report includes information on spending for \$198 million in discretionary HCFAC funds that Congress appropriated for the first time in FY 2009 - money that was intended to augment funds provided through the original HIPAA statute. Of this total, approximately \$38 million went to DOJ and OIG to expand investigative and law enforcement activities.

The bulk of this new HCFAC money, or \$160 million, went to CMS, largely for prevention and cost avoidance activities. More than half of CMS's share was used to strengthen oversight of Medicare Advantage and the Part D prescription drug benefit, the first dedicated funding source for this work since these programs were established. CMS also used this funding to begin developing an integrated data repository that will eventually be used by law enforcement to obtain real time data on claims trends that can be used to detect Medicare and Medicaid fraud, waste, and abuse.

In addition, these funds were used to set up a beneficiary fraud hot line in South Florida, enhance screening of new durable medical equipment suppliers, test new anti-fraud interventions in fraud hot spots, and employ new automated prepayment edits to prevent improper or fraudulent claims from being paid.

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