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United States General Accounting Office
Washington, DC 20548

Accounting and Information
Management Division

B-285846

July 31, 2000

Congressional Committees

Subject: Medicare: Health Care Fraud and Abuse Control Program Financial Reports for Fiscal Years 1998 and 1999

The Congress enacted the Health Care Fraud and Abuse Control (HCFAC) Program as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191. HCFAC, which is administered by the Department of Health and Human Services' Office of Inspector General (HHS/OIG) and the Department of Justice (DOJ), established a national framework to coordinate federal, state, and local law enforcement efforts to detect, prevent, and prosecute health care fraud and abuse in the public and private sectors.

HIPAA requires HHS and DOJ to issue a joint annual report to the Congress for the preceding fiscal year on (1) amounts deposited to the Federal Hospital Insurance Trust Fund[1] pursuant to HIPAA and the source of the amounts and (2) amounts appropriated from the trust fund for the HCFAC program and the justification for the expenditure of such amounts. HHS and DOJ have issued three joint reports, which covered fiscal years 1997,[2] 1998,[3] and 1999[4] deposits to the trust fund and allocation of the HCFAC appropriation.

HIPAA, as amended by the Balanced Budget Act of 1997, Public Law 105-33, also requires that we submit reports by June 1, 1998,[5] and by January 1, 2000, 2002, and

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[1]The Hospital Insurance Trust Fund funds the Medicare Part A program, which helps pay for hospital, home health, skilled nursing facility, and hospice care for the aged and disabled. The trust fund is funded primarily through employment taxes (taxes on payroll and self-employment).

[2]*Annual Report of the Departments of Health and Human Services and Justice, Health Care Fraud and Abuse Control Program 1997* (January 1998).

[3]*Annual Report of the Departments of Health and Human Services and Justice, Health Care Fraud and Abuse Control Program 1998* (February 1999).

[4]*Annual Report of the Departments of Health and Human Services and Justice, Health Care Fraud and Abuse Control Program 1999* (January 2000).

[5]*Medicare: Health Care Fraud and Abuse Control Program Financial Report for Fiscal Year 1997* (GAO/AIMD-98-157, June 1, 1998).

2004, that identify (1) the amounts collected (deposited to) on behalf of the trust fund pursuant to HIPAA and the sources of such amounts, (2) the amounts appropriated from the trust fund for the HCFAC program and the justification for the expenditures of such amounts, (3) expenditures from the trust fund for HCFAC activities not related to Medicare, and (4) any savings to the trust fund, as well as other savings, resulting from expenditures from the trust fund for the HCFAC program. In addition, HIPAA requires that we report on other aspects of the operation of the trust fund, as we consider appropriate, such as determining the status of development and implementation of the Healthcare Integrity and Protection Data Bank (HIPDB).

The HHS/DOJ joint report for fiscal year 1999, which was not required to be issued until January 2000, contained information needed to perform our review. Therefore, as we reported to you in December 1999,[6] we were unable to meet our reporting deadline of January 1, 2000, and, in all likelihood, we will be unable to meet our 2002 and 2004 commitments as well. This report presents the results of our review of fiscal years 1998 and 1999 HCFAC program activities.

Results in Brief

The HHS and DOJ joint HCFAC reports for fiscal years 1998 and 1999 reported that $107.4 million and $114.4 million, respectively, were deposited into the trust fund pursuant to HIPAA.[7] The sources of these deposits, as shown in the joint reports, were primarily penalties and damages ($103 million in fiscal year 1998 and $73.6 million in fiscal year 1999) and criminal fines ($2.5 million in fiscal year 1998 and $36 million in fiscal year 1999) resulting from health care fraud audits, evaluations, investigations, and litigation. The joint reports also stated that $119.6 million in fiscal year 1998 and $137.2 million in fiscal year 1999 were appropriated from the trust fund for the HCFAC program. Of those amounts, HHS and DOJ allocated $85.7 million in fiscal year 1998 and $98.2 million in fiscal year 1999 to the HHS/OIG to continue its Medicare and Medicaid fraud enforcement activities.[8] The remaining $33.9 million in fiscal year 1998 funds and $39 million in fiscal year 1999 funds were allocated to

- DOJ, which received $28.5 million in fiscal year 1998 and $30.7 million in fiscal year 1999 primarily to continue its litigative efforts and to provide health care fraud training, and

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[6] *Medicare: Reporting on the Health Care Fraud and Abuse Control Program for Fiscal Years 1998 and 1999* (GAO/AIMD-00-51R, December 13, 1999).

[7] Health care fraud activities also resulted in the collection of other amounts in fiscal years 1998 and 1999 that HIPAA did not require to be deposited into the Medicare trust fund, including recovered OIG audit disallowances and restitution/compensatory damages. Such amounts reported in HHS' and DOJ's fiscal years 1998 and 1999 joint HCFAC reports totaled $376.1 million and $189.1 million, respectively. Because HIPAA does not require these amounts to be deposited into the Medicare trust fund, they were not covered in our review. Therefore, we did not verify the reported amounts. According to HHS and DOJ, these amounts are returned to the trust fund to the extent that they represent repayments to the Medicare program.

[8] The maximum annual HCFAC appropriation authorized by HIPAA for HHS/OIG was $90 million in fiscal year 1998 and $100 million in fiscal year 1999.

- other HHS organizations, which received $5.5 million in fiscal year 1998 and $8.2 million in fiscal year 1999 for a variety of activities, including the development of a new adverse action[9] databank.

Based on our review of selected deposit, allocation, and expenditure transactions, we found that these transactions were related to HIPAA deposits, allocations, and expenditures as reported by HHS and DOJ in their joint reports. In addition, we found no material weaknesses in HHS' and DOJ's processes for accumulating HCFAC deposit, allocation, and expenditure information.

We could not identify expenditures from the trust fund for HCFAC activities not related to Medicare because neither the HHS/OIG nor DOJ separately account for or monitor those expenditures. HIPAA restricts the HHS/OIG officials' use of HCFAC funds to Medicare and Medicaid activities. HHS/OIG officials acknowledged that as permitted by HIPAA, some HCFAC funds were spent on efforts related only to Medicaid; however, the HHS/OIG does not separately track such expenditures. Likewise, DOJ does not separately account for non-Medicare and Medicaid expenditures. Furthermore, health care fraud cases often involve more than one health care program, which increases the difficulty in identifying non-Medicare expenditures. Neither HHS nor DOJ officials believe it is practical or beneficial to separately account for non-Medicare expenditures because of the nature of health care fraud cases.

We also could not determine the magnitude of savings to the trust fund, or other savings, resulting from the HCFAC trust fund expenditures during fiscal years 1998 and 1999. However, the HHS/OIG reported $10.8 billion and $11.8 billion for fiscal years 1998 and 1999, respectively, in cost savings[10] of health care funds as a result of its recommendations or other initiatives. Of the reported cost savings amounts, $2.6 billion in fiscal year 1998 and $1 billion in fiscal year 1999 were related to the Medicaid program, which is funded through the general fund of the Treasury, not the trust fund. Since audit, evaluation, investigation, and litigation activities typically span several years, savings from such activities initiated in fiscal years 1998 and 1999 are not expected to be realized until future years.

Finally, HIPDB opened for reporting on November 22, 1999, and for querying on March 6, 2000. However, implementation of HIPDB was postponed primarily as a result of the delayed issuance of final governing regulations. HIPAA required the Secretary of HHS to establish by January 1, 1997, a national health care fraud and abuse data collection program to collect and maintain information on final adverse actions taken against health care providers, suppliers, and practitioners. HIPDB is an important tool to keep unscrupulous providers from having access to Medicare and other health care programs.

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[9]Adverse actions include criminal convictions, civil judgments, and other actions against health care providers, suppliers, and practitioners.

[10]Cost savings are estimated savings that result from health care funds not being expended in future years because of legislative or regulatory changes. Cost savings differ from collections that are deposited to the fund.

We received technical comments from HHS and Justice which we have incorporated in the report as appropriate.

Background

As reported in our high-risk series,[11] the HHS/OIG reported that in fiscal year 1997 about 11 percent of health expenditures nationwide did not comply with Medicare laws and regulations, thus making Medicare inherently vulnerable to fraud and abuse. For the Medicare fee-for-service program, the HHS/OIG reported that an estimated 7.1 percent of payments, or $12.6 billion, in fiscal year 1998[12] and 7.97 percent of payments, or $13.5 billion, in fiscal year 1999[13] were improper. The Congress enacted HIPAA, in part, to respond to the problem of health care fraud and abuse. HIPAA consolidated and strengthened ongoing efforts to attack fraud and abuse in health programs and provided new criminal enforcement tools as well as expanded resources for fighting health care fraud, including $120 million in fiscal year 1998 and $137 million in fiscal year 1999.

Under the joint direction of the Attorney General and the Secretary of HHS (acting through the HHS/OIG), the HCFAC program goals are as follows:

- coordinate federal, state, and local law enforcement efforts to control fraud and abuse associated with health plans;
- conduct investigations, audits, and other studies of delivery and payment for health care for the United States;
- facilitate the enforcement of the civil, criminal, and administrative statutes[14] applicable to health care;
- provide guidance to the health care industry, including the issuance of advisory opinions, safe harbor notices, and special fraud alerts; and
- establish a national database of adverse actions against health care providers.

Funds for the HCFAC program are appropriated from the trust fund to a newly created expenditure account, referred to as the Health Care Fraud and Abuse Control Account, maintained within the trust fund. The Attorney General and the Secretary of HHS jointly certify that the funds transferred to the control account are necessary to finance health care antifraud and abuse activities, subject to limits for each fiscal year as specified by HIPAA. HIPAA authorizes annual minimum and maximum amounts earmarked for HHS/OIG activities for the Medicare and Medicaid programs.

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[11] *High-Risk Series: An Update* (GAO/HR-99-1, January 1999).

[12] *Report on the Financial Statement Audit of the Health Care Financing Administration for Fiscal Year 1998*, HHS/OIG, A-17-98-00098, February 1999.

[13] *Report on the Financial Statement Audit of the Health Care Financing Administration for Fiscal Year 1999*, HHS/OIG, A-17-00-00500, February 2000.

[14] These statutes include sections 1128, 1128A, and 1128B of the Social Security Act, as well as other statutes that apply to health care fraud and abuse.

For example, of the $137 million available in fiscal year 1999, a minimum of $90 million and a maximum of $100 million were earmarked for the HHS/OIG. By earmarking funds specifically for the HHS/OIG, the Congress ensured continued efforts by the HHS/OIG to detect and prevent fraud and abuse in the Medicare and Medicaid programs.

DOJ and HHS refer to the difference between the maximum annual HCFAC appropriation and the maximum amount earmarked for the HHS/OIG as the "wedge amount." If the HHS/OIG is allocated less than the maximum statutory amount, the difference is added to the wedge amount, which is available to fund HCFAC activities at other HHS entities. See enclosure I for additional details regarding HCFAC funding.

HIPAA also requires amounts equal to the following types of collections to be deposited in the trust fund:

- criminal fines recovered in cases involving a federal health care offense, including collections pursuant to section 1347 of Title 18, U.S.C.;
- civil monetary penalties and assessments imposed in health care fraud cases;
- amounts resulting from the forfeiture of property by reason of a federal health care offense;
- penalties and damages obtained and otherwise creditable to miscellaneous receipts of the Treasury's general fund obtained under the False Claims Act (sections 3729 through 3733 of Title 31, U.S.C.), in cases involving claims related to the provision of health care items and services (other than funds awarded to a relator,[15] for restitution, or otherwise authorized by law); and
- unconditional gifts and bequests.

HIPAA required the Secretary of HHS to establish by January 1, 1997, a national health care fraud and abuse data collection program to collect and maintain information on final adverse actions[16] taken against health care providers, suppliers, and practitioners. Federal and state government agencies and private health plans[17] are required to report to HHS regarding adverse actions taken against health care providers, suppliers, or practitioners. HIPAA requires HHS, in collecting information and responding to queries, to protect the privacy of patients. Upon request, HHS must disclose adverse action information to the health care providers, suppliers, and practitioners that are the subjects of the reports,[18] and must develop procedures for

[15]A relator is a private citizen who files suit on behalf of the federal government under the *qui tam*–whistle blower–provisions of the False Claims Act.

[16]Adverse action information stored in the data collection program would not include settlements in which no findings or admissions of liability were made.

[17]These same agencies and health plans are permitted to query the data bank regarding adverse actions reported.

[18]Health care providers, suppliers, or practitioners are granted access only to their own records.

these subjects to follow in disputing the information. HIPAA also provided HHS with the authority to charge reasonable fees (federal agencies exempted) for the disclosure of the information in the data bank. The fees are intended to cover the full costs of operating the HIPDB. Finally, HIPAA requires that HHS, in establishing the HIPDB, avoid duplication with the reporting requirements for the National Practitioner Data Bank (NPDB).[19]

Objectives, Scope, and Methodology

To identify amounts deposited to the trust fund in fiscal years 1998 and 1999 pursuant to HIPAA and the sources of these amounts, we reviewed HHS' and DOJ's fiscal years 1998 and 1999 joint HCFAC reports. We also obtained the trust fund's fiscal years 1998 and 1999 income statements, which received an unqualified opinion from the independent auditor, KPMG LLP. We compared amounts shown in the joint report as deposits of penalties and multiple damages, criminal fines, civil monetary penalties, and gifts and bequests with the respective amounts reported on the trust fund's audited income statements. In addition, we selected 56 deposits totaling $89.4 million in fiscal year 1998 and 84 deposits totaling $88 million in fiscal year 1999, focusing on large dollar amounts and unusual items. We tested the selected transactions to determine whether they were classified correctly as deposits to the trust fund. Further, we interviewed personnel at various HHS and DOJ entities to gain an understanding of procedures and controls related to collection and reporting deposits.

We reviewed the joint HCFAC reports to identify amounts appropriated from the trust fund in fiscal years 1998 and 1999 for the HCFAC program and the reported justification for expenditures of such amounts, as well as to identify expenditures from the trust fund for HCFAC activities not related to Medicare. We also reviewed documentation to support the allocation of the HCFAC appropriation, such as HHS' and DOJ's funding decision memorandum, proposals for the use of the wedge amount, and reallocation documents. In addition, we selected 13 expenditures and obligations totaling $3.6 million in fiscal year 1998 and 9 expenditures and obligations totaling $2.5 million in fiscal year 1999, focusing on large items. We tested the selected transactions to determine whether they were justified for fraud- and abuse-related activities. Because HHS/OIG's payroll costs were predominately allocated to the HCFAC appropriation, rather than accounted for directly, we reviewed its allocation methodologies to determine whether the methodologies were reasonable for reporting related expenditures, including non-Medicare expenditures. Further, we interviewed personnel at various HHS and DOJ entities to gain an understanding of their procedures for allocating the HCFAC appropriation and reporting related expenditures, including non-Medicare expenditures.

[19]NPDB was established by Public Law 99-660, Health Care Quality Improvement Act of 1986, and has been operating since September 1990. NPDB collects reports of medical malpractice payments made on behalf of health care practitioners as well as adverse actions reported by licensing agencies, those controlling clinical privileges, and professional societies.

To identify any savings to the trust fund, as well as any other savings, resulting from expenditures from the trust fund for the HCFAC program, we reviewed the joint reports. We also reviewed all recommendations and the resulting cost savings as reported in the HHS/OIG's fiscal years 1998 and 1999 semiannual reports[20] to determine whether such cost savings related to the HCFAC program. In addition, we selected 10 cost savings items totaling $8.6 million from fiscal year 1998 semiannual reports and 10 cost savings items totaling $10.7 million from fiscal year 1999 semiannual reports. We tested the selected transactions by reviewing supporting documentation to determine whether such cost savings related to fiscal years 1998 and 1999 and were adequately substantiated. Further, we interviewed HHS/OIG personnel to determine their methodologies for estimating cost savings.

We reviewed deposit, appropriation, and cost savings information reported in the joint reports. The joint reports are the responsibility of HHS and DOJ management. Our review of reported trust fund deposit, appropriation, and savings information was conducted in accordance with standards established by the American Institute of Certified Public Accountants (AICPA) *Amendments to Statement on Standards for Attestation Engagements Nos. 1, 2, and 3*, published in January 1999. A review has a narrower scope than an audit, the objective of which is to express an opinion. Accordingly, we do not express an opinion on amounts reported in the HHS and DOJ fiscal years 1998 and 1999 joint reports.

In response to HIPAA's provision that we report on other aspects of the operation of the trust fund as we consider appropriate, we reviewed the status of HIPDB, the national health care fraud and abuse data collection program, which is a requirement of HIPAA. To gain an understanding of the program's implementation and current status, we reviewed the program status report prepared by the Health Resources and Services Administration (HRSA). We also interviewed knowledgeable personnel responsible for HIPDB's development and reviewed various documents relating to the program. Specifically, we discussed the planning and current status of the data bank with personnel from HHS/OIG and HRSA, the organizations primarily responsible for HIPDB. We did not perform a systems review of HIPDB.

We interviewed and obtained documentation from officials at the Health Care Financing Administration (HCFA) in Baltimore, Maryland; HHS headquarters–including HHS/OIG, the Administration on Aging, and the Office of General Counsel–in Washington, D.C.; HRSA and HHS' Program Support Center in Rockville, Maryland; and DOJ's Justice Management Division, Executive Office for the United States Attorneys, Criminal Division, and Civil Division, in Washington, D.C.

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[20] *Department of Health and Human Services, Office of Inspector General, Semiannual Report, October 1, 1997 Through March 31, 1998*; *Department of Health and Human Services, Office of Inspector General, Semiannual Report, April 1, 1998, Through September 30, 1998*; *Department of Health and Human Services, Office of Inspector General, Semiannual Report, October 1, 1998 Through March 31, 1999*; and *Department of Health and Human Services, Office of Inspector General, Semiannual Report, April 1, 1999, Through September 30, 1999*. The Inspector General Act of 1978 (Public Law 95-452), as amended, requires the HHS/OIG to submit semiannual reports on its activities and accomplishments for the reporting period to the HHS Secretary for transmittal to the Congress.

We conducted our work in two phases, from April 1999 through July 1999, focusing primarily on fiscal year 1998 HCFAC activity, and from March 2000 through July 2000, focusing primarily on fiscal year 1999 HCFAC activity, in accordance with generally accepted government auditing standards, which incorporate AICPA standards and provide additional auditing standards. We requested comments on a draft of this report from the Secretary of HHS and the Attorney General or their designees. HHS provided us with written comments, which are discussed in the "Agency Comments" section and reprinted in enclosure II. We received technical comments from DOJ's designee for HCFAC activities. HHS' and DOJ's comments have been incorporated in our report as appropriate.

Amounts Deposited to the Trust Fund

HHS and DOJ reported total deposits of $107.4 million and $114.4 million to the trust fund in fiscal years 1998 and 1999, respectively, pursuant to HIPAA. These deposits are reported primarily as penalties and multiple damages obtained under the False Claims Act[14] and criminal fines.

Table 1 presents the total deposits to the trust fund in fiscal years 1998 and 1999 pursuant to HIPAA as reported by HHS and DOJ in their joint HCFAC reports for fiscal years 1998 and 1999.

Table 1: Reported Fiscal Years 1998 and 1999 Deposits to the Trust Fund Pursuant to HIPAA (Unaudited)

(Dollars in millions)		
Source of deposit	**FY 1998 amount**	**FY 1999 amount**
Penalties and multiple damages	$103.0	$73.6
Criminal fines	2.5	36.0
Civil monetary penalties	1.9	4.8
Gifts and bequests	[a]	[a]
Total[b]	**$107.4**	**$114.4[c]**

[a]Gifts and bequests totaled $3,000.00 for fiscal year 1998 and $2,500.00 for fiscal year 1999.

[b]HIPAA also requires that amounts resulting from the forfeiture of property in federal health care cases be deposited to the trust fund; however, there were no such reported forfeitures in fiscal years 1999 and 1998.

[c]To show their total fraud and abuse efforts, HHS and DOJ included in their joint reports other amounts collected as a result of health care fraud activities totaling about $376.1 million and $189.1 million in fiscal years 1999 and 1998, respectively. Because HIPAA does not require that these amounts be deposited to the trust fund, they were not covered by our review. According to HHS and DOJ, to the extent that they represent repayments to Medicare, these amounts are returned to the trust fund.

Source: *Annual Report of the Departments of Health and Human Services and Justice, Health Care Fraud and Abuse Control Program 1998* (February 1999) and *Annual Report of the Departments of Health and Human Services and Justice, Health Care Fraud and Abuse Control Program 1999* (January 2000).

Based on our review of HIPAA deposits, nothing came to our attention that caused us to believe that HHS and DOJ did not accurately classify the deposits in their fiscal years 1998 and 1999 joint HCFAC reports. In addition, we found no material weaknesses in HHS' and DOJ's processes for accumulating HIPAA deposits.

[14]Sections 3729 through 3733 of Title 31,U.S.C.

Penalties and damages obtained under the False Claims Act and criminal fines resulting from health care fraud cases, as reported by HHS and DOJ, composed 98 percent and 96 percent, respectively, in fiscal years 1998 and 1999, of the deposits to the trust fund pursuant to HIPAA. DOJ's Civil Division in Washington, D.C., and Financial Litigation Units in the United States Attorneys' offices located throughout the country collect penalties and damages resulting from health care fraud cases. They report collection information to DOJ's Debt Accounting Operations Group, which in turn accounts for collections of penalties and multiple damages and reports to the Department of the Treasury the amounts to be deposited to the trust fund. Clerks of the Administrative Office of the United States Courts, who are located throughout the country, collect criminal fines resulting from health care fraud cases and report these collections to the Financial Litigation Units associated with their districts. The Financial Litigation Units then report the fine collections to DOJ's Executive Office for the United States Attorneys in Washington, D.C., which centrally reports the amount of criminal fines collected to the Department of the Treasury.

We found that the amounts in the joint reports shown as deposits of penalties and multiple damages, criminal fines, civil monetary penalties, and gifts and bequests agreed with the respective amounts reported on the trust fund's audited income statements for fiscal years 1998 and 1999. In addition, we found that the 56 deposit transactions we reviewed totaling $89.4 million were accurately classified and reported as HIPAA deposits to the trust fund in fiscal year 1998. We also found that 84 deposit transactions we reviewed totaling $88 million were accurately classified and reported as deposits to the trust fund in fiscal year 1999.

We also found that some deposits reported in fiscal years 1998 and 1999 resulted primarily from actions initiated prior to those years. According to DOJ officials, investigation and litigation of health care fraud cases generally span several years. After cases are settled, it may take several more years before any resulting fines, penalties, and damages are paid in full. Consequently, deposits to the trust fund reported in fiscal years 1998 and 1999 pursuant to HIPAA essentially resulted from prior years' investigation and litigation efforts. Similarly, investigation and litigation activities initiated in fiscal years 1998 and 1999 will most likely result in collections in future years.

Amounts Appropriated From the Trust Fund

In fiscal years 1998 and 1999, the Attorney General and the Secretary of HHS certified the entire $119.6 million and $137.2 million in appropriations, respectively, as necessary to carry out the HCFAC program. Based on our review, nothing came to our attention that caused us to believe that the allocation process for HCFAC appropriations was not justified for fraud and abuse activities. The Attorney General and the Secretary of HHS entered into a memorandum of understanding that laid the groundwork for allocating funds among program participants. In applying for funds, applicants were required to explain how their proposed activities conformed to the statute and the HCFAC program and to provide a spending plan. HHS and DOJ

jointly reviewed proposals and made funding decisions for the HCFAC funds. Table 2 presents fiscal years 1998 and 1999 allocations for the HCFAC program.

Table 2: Fiscal Years 1998 and 1999 Allocations (Unaudited)

(Dollars in thousands)		
Organization	**FY 1998 amount**	**FY 1999 amount**
HHS		
HHS/OIG	$85,680	$98,220
Office of the General Counsel	2,200	2,292
Administration on Aging	1,300	1,400
HRSA	1,000	4,443
HCFA	950	0
Departmental Appeals Board	0	138
DOJ		
United States Attorneys	23,856	21,538
Civil Division	3,803	8,119
Criminal Division	561	803
Justice Management Division	250	280
Total	**$119,600**	**$137,233**

Source: Allocation information was obtained from the *Annual Report of the Departments of Health and Human Services and Justice, Health Care Fraud and Abuse Control Program 1998* (February 1999) and *Annual Report of the Departments of Health and Human Services and Justice, Health Care Fraud and Abuse Control Program 1999* (January 2000).

Although HIPAA authorized up to $90 million and $100 million in fiscal years 1998 and 1999, respectively, for HHS/OIG's Medicare fraud and abuse enforcement activities, the HHS/OIG requested and was granted $85.7 million and $98.2 million, respectively. HHS/OIG strategically increased resources dedicated to fraud activities, enhanced existing Medicare fraud protection activities, and pursued new antifraud initiatives. The HHS/OIG reported that HCFAC funding allowed it to open seven new investigative offices during fiscal years 1998 and 1999 and increase its staff levels by 132 and 105 in fiscal years 1998 and 1999, respectively. The HHS/OIG also significantly increased its staffing resources devoted to ensuring health care providers' compliance with federal health care program rules.

In fiscal years 1998 and 1999, wedge funds[21] allocated to other federal, state, and local agencies were $34 million and $39 million, respectively. Table 3 presents fiscal years 1998 and 1999 wedge amounts for the HCFAC program.

[21]Wedge funds represent the difference between the maximum annual HCFAC appropriation and the maximum amount earmarked for the HHS/OIG.

Table 3: Fiscal Years 1998 and 1999 Wedge Amounts (Unaudited)

(Dollars in millions)		
Organization	**FY 1998 amount**	**FY 1999 amount**
DOJ	$28.5	$30.7
HCFA	1.0	0.0
HRSA	1.0	4.4
Office of General Counsel	2.2	2.3
Other HHS organizations	1.3	1.5
Total	**$34.0**	**$38.9**

Source: Fiscal years 1998 and 1999 Health Care Fraud and Abuse Control (HCFAC) Account Funding Agreement – Action Memorandum.

The wedge amounts were used for the following purposes in fiscal years 1998 and 1999:

- The Department of Justice's wedge amount was used primarily to continue its efforts to litigate health care fraud cases and provide health care fraud training courses.
- HCFA, the agency with primary responsibility for administering the Medicare and Medicaid programs, used the wedge funds allocated in fiscal year 1998 to continue its satellite office operations in Miami, Florida, and to open a new satellite office in New Orleans, Louisiana. Satellite offices support newly established, cross-jurisdictional partnerships with various entities that had previously worked in isolation to combat fraud. HCFA's wedge funds were also used to support continuation of state survey and certification projects.
- HRSA used wedge funds to design and implement the adverse action database, HIPDB, the status of which is discussed later in this letter.
- The HHS Office of the General Counsel's wedge funds were used for health care fraud litigation activity, both administrative and judicial.
- Other HHS organizations, such as the Administration on Aging and Departmental Appeals Board, were allocated funds for health care fraud and abuse prevention and detection activities.

HCFA performs the accounting for the control account, from which all HCFAC expenditures are made. HCFA sets up allotments in its accounting system for each of the HHS and DOJ entities receiving HCFAC funds. The HHS and DOJ entities account for their HCFAC obligations and expenditures in their respective accounting systems and report them to HCFA monthly. HCFA then records the obligations and expenditures against the appropriate allotments in its accounting system.

We reviewed supporting documentation, such as obligating documents and invoices, for 13 expenditure and related obligation transactions totaling $3.6 million in fiscal year 1998 and 9 expenditure and related obligation transactions totaling $2.5 million in fiscal year 1999. In addition, we reviewed the methodology used to allocate payroll costs to the HCFAC program at the HHS/OIG and DOJ. We found that (1) the expenditures and obligations we tested related to HHS funding decisions and the proposals approved for HCFAC funds and (2) the transactions appeared justified for

fraud and abuse activities. In addition, we found no additional material weaknesses in the payroll cost allocation methodologies we reviewed.

Non-Medicare Expenditures

We were not able to identify HCFAC program trust fund expenditures that were unrelated to Medicare because the HHS/OIG and DOJ do not separately account for or monitor such expenditures. HIPAA restricts the HHS/OIG's use of HCFAC funds to Medicare and Medicaid programs. According to HHS/OIG officials, they use HCFAC funds only for audits, evaluations, or investigations related to Medicare and Medicaid. The officials also stated that while some activities may be limited to either Medicare or Medicaid, most activities are generally related to both programs. Because HIPAA does not preclude the HHS/OIG from using HCFAC funds for Medicaid efforts, the HHS/OIG does not believe it is necessary or beneficial to account for such expenditures separately.

Similarly, DOJ officials believe that it is not practical or beneficial to separately account for non-Medicare expenditures because of the nature of health care fraud cases. HIPAA permits DOJ to use HCFAC funds for health care fraud activities involving other health programs. According to DOJ officials, health care fraud cases usually involve several health care programs, including Medicare and health care programs administered by other federal agencies, such as the Department of Veterans Affairs, the Department of Defense, and the Office of Personnel Management. Consequently, it is difficult to separately charge personnel costs and other litigation expenses to specific parties in health care fraud cases. Also, according to DOJ officials, even if Medicare is not a party in a health care fraud case, the case may provide valuable experience in health care fraud matters, allowing auditors, investigators, and attorneys to become more effective in their efforts to combat Medicare fraud. Neither HHS nor DOJ have plans to identify these expenditures in the future.

Savings to the Trust Fund

Because of the nature of health care antifraud and abuse activities, we were unable to quantify the savings to the trust fund, or any other savings that resulted from expenditures from the trust fund due to the nature of health care antifraud and abuse activities. As discussed earlier, audits, evaluations, and investigations can take several years to complete. Once they have been completed, it can take several more years before recommendations or initiatives are implemented. Likewise, it is not uncommon for litigation activities to span many years before a settlement is reached. Consequently, any savings resulting from health care antifraud and abuse activities funded by the HCFAC program in fiscal years 1998 and 1999 will likely not be realized until subsequent years.

In their joint reports, HHS and DOJ reported approximately $10.8 billion of cost savings during fiscal year 1998 and $11.8 billion of cost savings during fiscal year 1999 from implementation of HHS/OIG recommendations and other initiatives. Of the reported cost savings, $2.6 billion in fiscal year 1998 and $1 billion in fiscal year 1999

were reported as related to the Medicaid program, which is funded through the general fund of the Treasury, not the Medicare trust fund. Cost savings are annualized amounts that are determined based on Congressional Budget Office estimates over a 5-year period. Because the HHS/OIG's recommendations and other initiatives relate to actions that predate the HCFAC program, the cost savings cannot be associated with expenditures from the trust fund pursuant to HIPAA. Nothing came to our attention to lead us to believe that the amounts reported as cost savings were inaccurate or unsupported.

Status of HIPDB

In our last report[22] on the HCFAC program, we briefly discussed HHS' plans to develop HIPDB. HIPAA required the Secretary of HHS to establish by January 1, 1997, a national health care fraud and abuse data collection program, HIPDB, to collect and maintain information on final adverse actions taken against health care providers, suppliers, and practitioners. HIPDB opened for reporting[23] on November 22, 1999, and for querying[24] on March 6, 2000. HHS' contractor developed a Web-based integrated querying and reporting system designed to route reports and query transactions to HIPDB.

The implementation of HIPDB was postponed primarily as a result of the delayed passage of final regulations governing it. HHS developed HIPDB in phases, based on the amount of HCFAC funds allotted and the timing of the issuance of final regulations governing how the HIPDB will operate. Under a memorandum of understanding,[25] HRSA was granted the authority to develop and implement HIPDB and was allotted $2 million from the HCFAC fiscal year 1997 appropriation to develop the first phase of HIPDB. HRSA requested and was granted an additional $1 million of the HCFAC fiscal year 1998 appropriation to maintain its contract and complete the development of HIPDB, pending the issuance of final regulations. HHS and DOJ officials suspended plans to open HIPDB until final regulations were published,[26] which was expected to occur in May 1999. In fiscal year 1999, HRSA requested and was granted a total of $4.4 million to continue the development of

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[22]GAO/AIMD-98-157, June 1, 1998.

[23]Federal and state government agencies and private health plans are required to report adverse actions taken against health care providers, suppliers, and practitioners.

[24]Federal and state government agencies and private health plans are permitted to query the data bank. However, health care providers, suppliers, and practitioners are granted access only to their own records.

[25]With agreement from HHS and DOJ, HHS/OIG entered into a memorandum of understanding with HRSA to develop and implement HIPDB. HRSA has hired a contractor to operate HIPDB.

[26]Although HHS could have operated the HIPDB under interim final rules, HHS officials determined that the agency could be sued if the HIPDB were implemented under interim final rules. Interim final rules become effective before public comments are received. They are subject to comment and may later be amended but are effective immediately upon issuance. Final rules are not issued until public comments have been received and changes have been made to the regulations.

HIPDB. Final regulations governing HIPDB were issued on October 26, 1999. HIPDB was available for reporting on November 22, 1999, and began accepting queries on March 6, 2000. The cumulative cost reported for the development and implementation of HIPDB was $7.4 million.

Agency Comments

In written comments, HHS offered some technical suggestions. DOJ provided oral comments which also were of a technical nature. We have incorporated the agencies' comments into this letter as appropriate.

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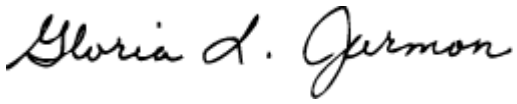
We are sending copies of this report to the Honorable Donna Shalala, Secretary of Health and Human Services; the Honorable Janet Reno, the Attorney General; and other interested parties. Copies will be made available to others on request. If you or your staff have any questions, please contact me at (202) 512-4476 or by email at *jarmon.aimd@gao.gov*. Key contributors to this letter are listed in enclosure III.



Gloria L. Jarmon
Director, Health, Education, and Human Services
Accounting and Financial Management Issues

Enclosures

Congressional Committees

The Honorable William V. Roth, Jr.
Chairman
The Honorable Daniel P. Moynihan
Ranking Minority Member
Committee on Finance
United States Senate

The Honorable James M. Jeffords
Chairman
The Honorable Edward M. Kennedy
Ranking Minority Member
Committee on Health, Education, Labor, and Pensions
United States Senate

The Honorable Tom Bliley
Chairman
The Honorable John D. Dingell
Ranking Minority Member
Committee on Commerce
House of Representatives

The Honorable Bill Archer
Chairman
The Honorable Charles B. Rangel
Ranking Minority Member
Committee on Ways and Means
House of Representatives

Additional Information on HCFAC Activities

HIPAA provided for appropriations of up to $104 million, $119.6 million, and $137.2 million to the control account for fiscal years 1997, 1998, and 1999, respectively. A minimum of $70 million, $85.7 million, and $98.2 million for fiscal years 1997, 1998, and 1999, respectively, was earmarked for HHS/OIG activities involving Medicare and Medicaid. Also, HIPAA provided for the appropriation of an additional $47 million, $56 million, and $66 million in fiscal years 1997, 1998, and 1999, respectively, from the general fund of the Treasury to the control account for transfer to the Federal Bureau of Investigation to (1) prosecute, investigate, and audit health care matters and (2) develop and deliver provider and consumer education regarding compliance with fraud and abuse provisions.[27]

HIPAA provides for annual increases of 15 percent in HCFAC funding through the year 2003, after which the appropriation for HCFAC and the amount earmarked for the HHS/OIG remains the same. Table 4 summarizes the HCFAC funding limits for fiscal years 1997 through 2003.

Table 4: Fiscal Year Funding Limits for the HCFAC Program Established by HIPAA

Fiscal year	Appropriation available	Amount available only to the HHS/OIG[a]	Wedge amount[b]
1997	$104,000,000	$70,000,000	$34,000,000
1998	$119,600,000	$85,680,000	$33,920,000
1999	$137,233,000[c]	$98,220,000	$39,013,000
2000	$158,171,000	$110,000,000-$120,000,000	$38,171,000
2001	$181,896,650	$120,000,000-$130,000,000	$51,896,650
2002	$209,181,147	$140,000,000-$150,000,000	$59,181,147
2003	$240,558,320	$150,000,000-$160,000,000	$80,558,320

[a]Table 4 includes the actual amounts allocated to the HHS/OIG in fiscal years 1997, 1998, and 1999. For fiscal years 2000 through 2003, the table includes the annual minimum and maximum amounts earmarked for the HHS/OIG. After 2003, the appropriation for HCFAC and the amount earmarked for the HHS/OIG remain the same.

[b]Consistent with HHS and DOJ's definition of the wedge amount, the fiscal years 1997, 1998, and 1999 wedge amounts are based on the actual amount allocated to the HHS/OIG, and the wedge amounts for fiscal years 2000 through 2003 are based on the maximum amount available only to the HHS/OIG.

[c]The original certification was for $137,540,000. However, during the fiscal year, a $307,000 recision was taken against the account, leaving $137,233,000 available.

For fiscal years 1997 through 1999, figure 1 shows the amounts appropriated to and figure 2 shows the HIPAA collections deposited into the Medicare Trust Fund.

[27]This report does not discuss the use of these funds because they were not appropriated from the trust fund.

Figure 1: HCFAC Appropriations From Fiscal Years 1997 Through 1999

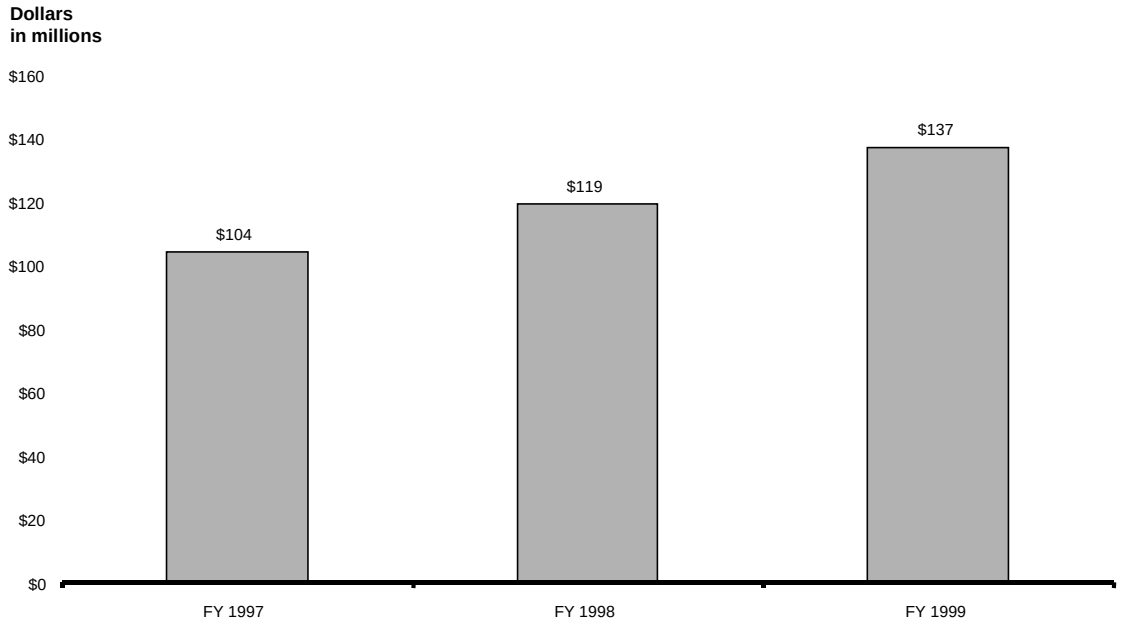
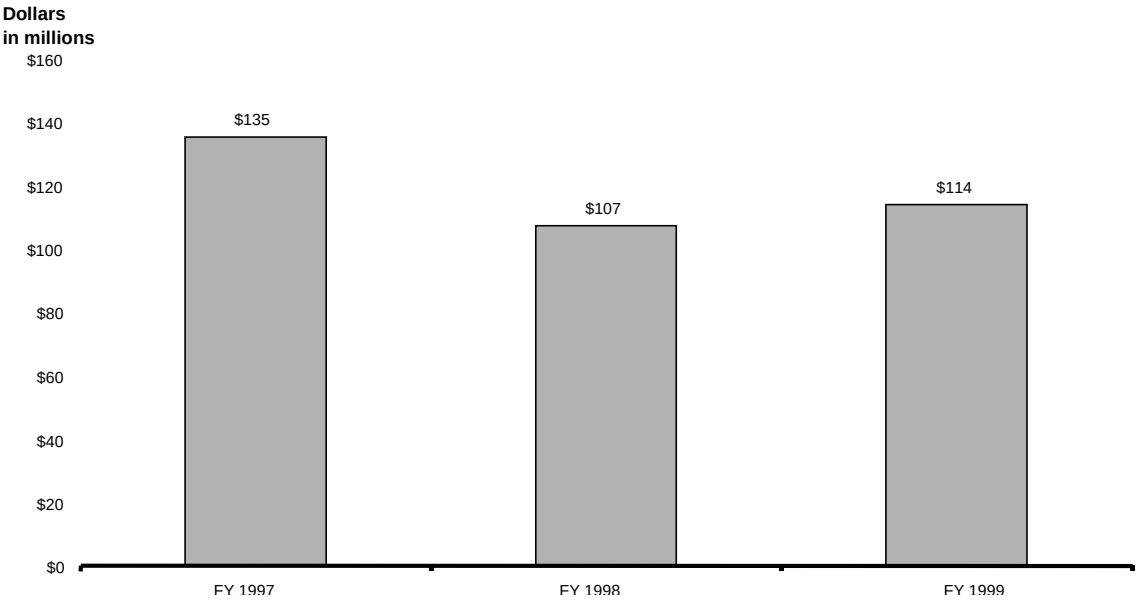


Figure 2: HIPAA Medicare Trust Fund Deposits From Fiscal Years 1997 Through 1999



Comments From the Department of Health and Human Services

Note: GAO comments supplementing those in the letter appear at the end of this enclosure.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

JUL 26 2000

Mr. Jeffrey C. Steinhoff
Assistant Comptroller General
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Steinhoff:

Enclosed are the Department's comments on your draft report, Medicare: Health Care Fraud and Abuse Control Program Financial Reports for Fiscal Years 1998 and 1999. The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely yours,

June Gibbs Brown
Inspector General

Enclosure

The Office of Inspector General (OIG) is transmitting the Department's response to this draft report in our capacity as the Department's designated focal point and coordinator for General Accounting Office reports. The OIG has not conducted an independent assessment of these comments and therefore expresses no opinion on them.

HHS Comments on GAO/AIMD-00-257R HCFAC 1998 and 1999

Now on p. 2.
See comment 1.

On page 5 of the HCFAC 1998 and 1999 Report, Monetary Results include $172,740,590 and $259,202,254 for OIG Audit Disallowances - Recovered, and Restitution/Compensatory Damages. We believe that the GAO report should recognize these amounts as accomplishments of the program. Although footnote c of Table 1 in the reports mentions these collections, they are excluded from the calculation of deposits to the trust fund. To the extent that these funds are returned to the Medicare program, they should be considered returned to the trust fund.

Now on p. 5.
See comment 2.

On page 7, of the GAO draft report, the third bullet indicates that "collections under section 982(a)(6) of Title 18, United States Code" are to be deposited in the account. This was an erroneous citation in the original HIPAA statute. Instead, the reference should be to section 24(a) of Title 18, United States Code." HHS submitted a legislative proposal to correct this mistake; the correction was made in the Consolidated Appropriations Act of 2000, and its effect was made retroactive to the date of enactment of HIPAA. The statute now reads "collections under section 24(a) of Title 18, United States Code."

Enclosure II

The following are GAO's comments on HHS/OIG's letter dated July 25, 2000.

GAO's Comments

1. We have added an additional footnote (footnote 7) to highlight this information in our "Results in Brief" section of this letter.

2. To avoid any misinterpretation, we have deleted the reference to the legal citation.

GAO Contacts and Staff Acknowledgments

GAO Contacts

Gloria L. Jarmon, (202) 512-4476
Kay L. Daly, (202) 512-9312
Sabrina L. Springfield, (202) 512-9328

Acknowledgments

In addition to those named above, Kwabena Ansong, Kim Brooks, William Brown, Christine Fant, Meg Mills, Timothy Murray, Chanetta Reed, and Sandra Silzer made key contributions to this report.

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