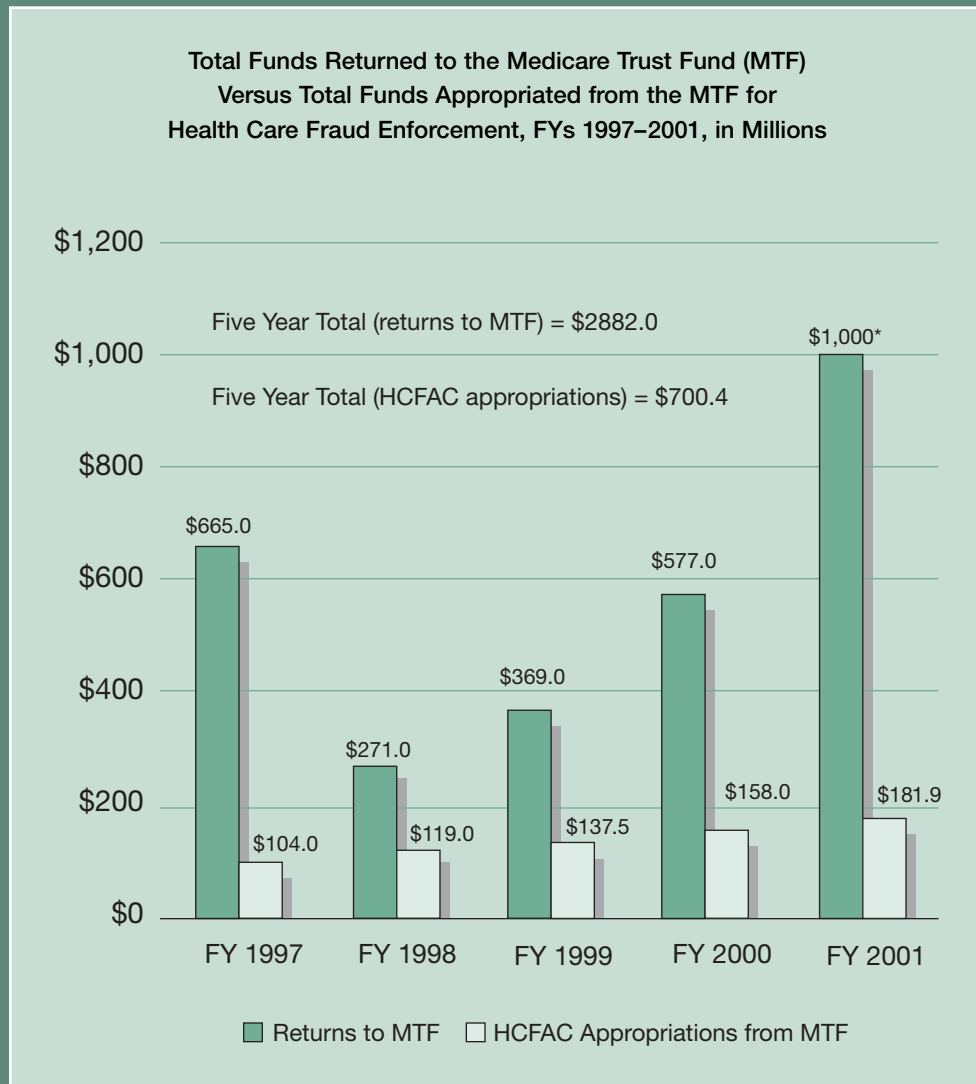


Fighting Medicare Fraud

More Bang for the Federal Buck

Prepared for
**Taxpayers Against Fraud
Education Fund**

by
**Jack A. Meyer
President
New Directions for Policy**



Fighting Medicare Fraud

More Bang for the Federal Buck

prepared for
Taxpayers Against Fraud Education Fund

by
Jack A. Meyer
President
New Directions for Policy

JUNE 2003

The author would like to thank Heather Sacks for valuable research assistance.

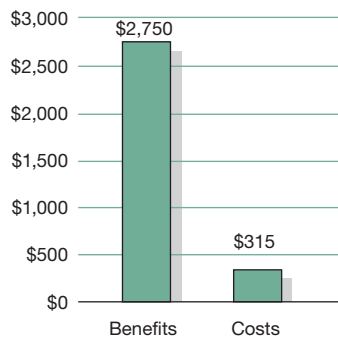
Statement of Purpose and Summary of Findings

While there is considerable debate over how to spend the taxpayers' dollars, most Americans would agree that they should not be stolen. The interest in reducing fraud against federal programs cuts across party lines and spans the ideological spectrum. In fact, bipartisan efforts to reduce fraud led in 1986 to amendments strengthening the False Claims Act (FCA), which establishes liability for contractors that commit fraud by submitting false or fraudulent claims for reimbursement to the federal government. These amendments enhanced the role of whistleblowers, or individuals with inside information about fraudulent practices of government contractors, facilitating their ability to sue fraudulent contractors on behalf of the federal government and increasing the amount of allowable recoveries.

The False Claims Act and its whistleblower provisions have been particularly effective in the fight against Medicare fraud. Medicare, the federal government's second largest social program, will spend some \$277 billion this year purchasing hospital, physician, and other medical care for nearly 40 million elderly and disabled Americans. In a six-month study conducted for Taxpayers Against Fraud (TAF) in 2001, we found that anti-fraud efforts returned nearly \$1.9 billion to the Medicare Trust Fund over the period FY 1997–FY 2000, and that a significant portion of these recoveries was attributable to FCA cases. Our study also found that, over this four-year period, the federal government was getting a direct monetary return of at least \$8 for every \$1 invested in health-related FCA enforcement activities.

Because of increasing interest in the FCA on the part of policymakers and the media, TAF requested that we update our study. Based on an analysis of data for the five-year period FY 1997–FY 2001, we conclude that the U.S. taxpayers are continuing to get an excellent return on their dollars invested in fighting fraud against the Medicare program. *Specifically, federal government recoveries from civil health care fraud over this period totaled \$3.1 billion; after deducting payments to whistleblowers, the net recoveries to the federal government amounted to \$2.75 billion over the 1997–2001 period (See Figure 1). In contrast, we estimate the government's costs at \$315 million. Thus, for every dollar spent to investigate fraud, recover funds obtained through illegal billings, and prosecute these civil cases, nearly nine dollars are received in return.* This order of magnitude of the rate of return on the govern-

Figure 1 Benefits and Costs of Federal Government Anti-Health Care Fraud Activities, FY 97-01 (in millions)



ment's investment makes this government expenditure unusual, if not unique.

Why did the federal government's return on investment improve from 8 to 1 to nearly 9 to 1? In short, the government's recoveries in FY 2001 increased far more rapidly than its enforcement costs. Civil health care fraud recoveries in FY 2001 were \$1.2 billion, up 71 percent from the previous year. In contrast, government enforcement costs were about \$72.8 million, an increase of only \$4.3 million, or about 6.3 percent, from the prior year. The large increase in recoveries in FY 2001 was attributable largely to a landmark \$745 million settlement agreement with the Hospital Corporation of America (HCA), the country's largest for-profit hospital chain, to settle civil allegations of fraud against Medicare and Medicaid. As discussed in our previous report, the series of FCA cases culminating in this December 2000 settlement was initiated by a whistleblower lawsuit filed by a financial officer in a small rural hospital in Montana in 1993. The \$745 million recovery was the largest single FCA settlement through September 30, 2001.

The benefit/cost ratio of nearly 9 to 1 is likely to underestimate the real return that the taxpayers are receiving on outlays for civil health care fraud enforcement. That is because, in addition to the actual monetary recoveries resulting from FCA investigations and prosecutions, there are also deterrent effects that affect the behavior of other firms in the industry. For example, we found in our previous study that a settlement agreement like that with HCA, involving as it did a leading firm in the industry and a huge payment to the government, had a ripple effect that reduced the likelihood of similar cost reporting fraud against the Medicare program. These deterrent effects can't be measured accurately, but they may be a substantial multiple of the direct, measurable benefits in the form of actual monetary recoveries.

The FCA and its whistleblower provisions are central to the federal government's anti-fraud efforts. They provide the federal government with the inside information it needs to uncover complex business fraud against Medicare and the clout it requires to recover stolen funds and deter future fraud. But the Department of Justice, which administers the FCA, must use its authority in a balanced manner. It must enforce the FCA with vigor, but it must also respect the rights of companies in the health care industry, continue to promote compliance plans that prevent fraud at the front end, and distinguish carefully between honest billing errors and fraud. If the provisions of the FCA are enforced in this fashion, it will continue to save large amounts of money for federal taxpayers and contribute to the fiscal viability of the Medicare program.

As we face difficult choices about controlling Medicare spending increases and adding a prescription drug benefit to the program, the last thing our society needs is a major drain on the Medicare program from fraud. Every dollar that is siphoned off from the program's funding sources by fraudulent billing practices makes the painful choices we face even harder. If fraud is not curtailed, it will be paid for by those enrolled in the program in the form of future benefit cuts and by working-age people in the form of higher taxes. Fraud will also be paid for by honest physicians, hospitals, and other health care providers whose rates will be further cut to help control the cost of the program. Each of these parties—seniors, taxpaying workers, and health care providers—has a financial stake in curtailing health care fraud.

Most hospitals, medical groups, laboratories, and insurers engage in honest business practices in dealing with the government. But the relatively few dishonest providers can spoil the day for the many honest providers and insurers. The federal government needs strong sanctions to deter big-time fraud. And because dishonest practices are now very complex, sophisticated, and difficult to detect, the government will continue to need the help of employees working inside health care providers' companies. Provisions of current law empowering and protecting whistleblowers must be maintained so that they can bring action against those perpetrating fraud without fear of retaliation. Potential damages must be large enough to matter to large corporations who could brush aside or ignore small penalties.

Findings

This section presents the key findings of this project. The report presents data on both recoveries and costs over the five-year period from federal fiscal years 1997 through 2001. This period is selected because most of the available data is only current through fiscal year 2001. It begins with the documentation of the latest findings on the federal government's *recoveries* from its work fighting health care fraud. We identify health care fraud recoveries for each of the five fiscal years over the 1997–2001 period. The next step is to update the trends in the federal government's *costs* in pursuing the perpetrators of fraud. Here we estimate the costs incurred by the DOJ's Civil Division, the United States Attorneys Offices (USAOs), and the Office of the Inspector General (OIG) at the U.S. Department of Health and Human Services. This tells us how much the taxpayers are laying out to obtain these recoveries. Finally, these costs are juxtaposed with the benefits to demonstrate the cost-effectiveness of the government's effort. What is the "bang for the buck" emerging

from government's anti-fraud initiatives?

Two aspects of our methodology are worth highlighting. First, in updating our earlier work, we have added an estimate of OIG's costs in pursuing health care fraud, which we were unable to measure in the first report. Second, the benefits, as measured here, are undoubtedly an underestimate of the full benefits resulting from the government's work. The recoveries represent the "hard-dollar" payback from the federal effort. But there is another, potentially very large component of the payback. This involves the *deterrent effect* that results from the government's successful initiatives and its large settlements with companies in the health care field. Firms doing business with Medicare now realize that they have a great deal at stake when they fraudulently bill the federal government. As already noted, they may be liable for huge damages, which may be large enough to substantially weaken the firm if not bring it to its knees. Further, they may be excluded from participating in Medicare, which may have similar effects. In certain cases, corporate officials may be subject to criminal prosecution. Criminal investigations at DOJ sometimes parallel civil FCA investigations.

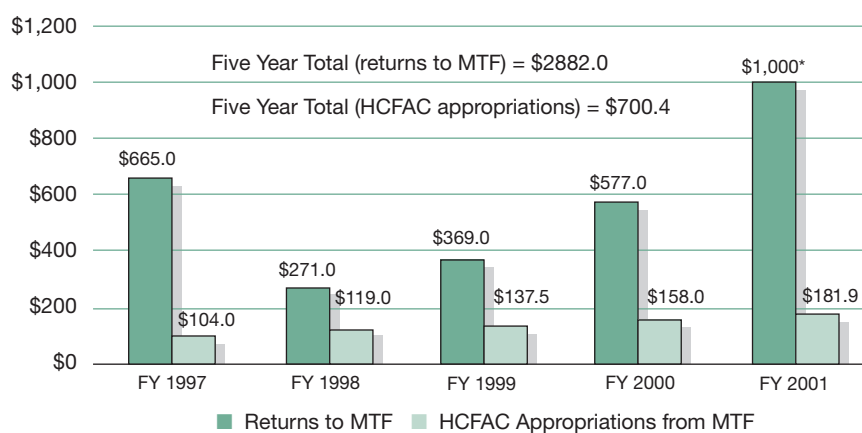
These aspects of our methodology suggest that our estimates are likely to be on the conservative side. Our results show that the benefit/cost ratio is higher now than when we measured it before (nearly nine to one in contrast with eight to one), even though we incorporated more government costs this time.

Many of the Justice Department's FCA investigations are based on information from private individuals (corporate whistleblowers or government program beneficiaries). Both DOJ and the Office of the Inspector General at the U.S. Department of Health and Human Services (OIG) uncover additional evidence of fraud through audits and coordinated investigations. Prosecution of the cases is usually conducted by one of the nation's 94 U.S. Attorneys (USAOs). In most cases, these USAOs are able to negotiate settlements with individuals and corporations accused of violating civil or criminal law.

Trends in Government Recoveries

Enforcement of the False Claims Act can make a modest, but significant contribution to the long-run solvency of the Medicare program. This occurs because *the bulk of the funds recovered from successful investigations and prosecutions of fraud are returned to the Medicare Trust Fund. (See Figure 2.) In fact, the money returned to the trust fund greatly exceeds the amount allocated to fighting health care fraud. In effect, money that has been stolen from senior*

Figure 2 Total Funds Returned to the Medicare Trust Fund (MTF) versus Total Funds Appropriated from the MTF for Health Care Fraud Enforcement, FYs 1997–2001 (in millions)



* This figure is an approximate estimate of the amount returned to the MTF. The Department of Health and Human Services and the Department of Justice Health Care Fraud and Abuse Control Program Annual Report for FY 2001 notes that \$1.3 billion was *collected* in 2001 and that “more than \$1 billion of the funds collected and disbursed in 2001 were returned to the Medicare Trust Fund.”

Source: The Department of Health and Human Services and the Department of Justice. Health Care Fraud and Abuse Control Program. Annual Reports for FY 1997–2001.

citizens and people with disabilities is returned to the program that is paying for their health care.

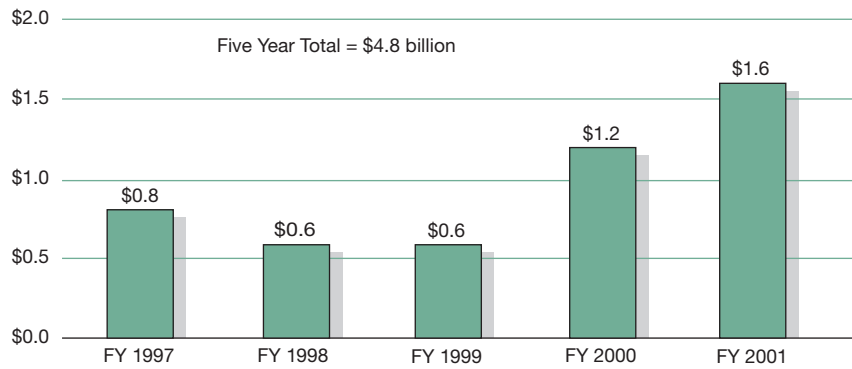
Looking first at the trend in overall civil fraud recoveries, we see that *the federal government brought in a total of \$4.8 billion over the 1997–2001 period, with one-third of that amount emerging in the last year—2001 (see Figure 3).* It is noteworthy that \$4.1 billion of this \$4.8 billion total over five years was attributable to cases brought by *qui tam* relators.

Of the total recoveries from civil fraud, *an estimated \$3.1 billion was related to health care fraud, or 65 percent of the total.* (see Figure 4)

All of the activity to fight fraud on the part of DOJ, OIG, and whistle-blowers has contributed to a dramatic reduction in the Medicare error rate. This rate fell from 14.0 percent of fee-for-service payments in 1996 to 11.4 percent in 1997, 7.1 percent in 1998, 8.0 percent in 1999, 6.8 percent in 2000, and 6.3 percent in 2001, a reduction of 55 percent over six years.¹ This translates into savings of more than \$12 billion a year in the fee-for-service portion of

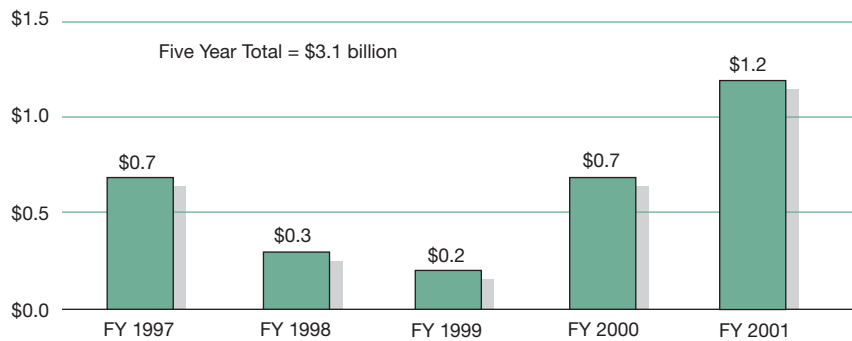
¹ Source: Department of Health and Human Services. Office of Inspector General. Memorandum from Janet Rehnquist to Thomas Scully. Subject of Improper Fiscal year 2001 Medicare Fee-for-Service Payments (A-17-01-02002). February 15, 2002.

Figure 3 Civil Fraud Recoveries Per Year, FYs 1997-2001 (in billions)



Source: U.S. Department of Justice, Budget Office, November 2001

Figure 4 Health-Related Civil Fraud Recoveries Per Year, FYs 1997-2001 (in billions)



Source: U.S. Department of Justice, Budget Office, November 2001.

Medicare. This is about double the size of the entire budget for the Health Resources and Services Administration, which runs vital health care programs in such areas as the Ryan White AIDS program; the National Health Service Corp that helps bring physicians and nurses into under-served areas; and the Maternal and Child Health Block Grant.

Trends in Government Costs

What is the federal government spending to achieve these results? The federal costs to fight fraud are financed in two ways. First, both DOJ and OIG in HHS receive funds from the Health Care Fraud and

Abuse Control (HCFAC) program. HCFAC is a national health care fraud prevention program set up under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. It is administered jointly by DOJ and HHS. HCFAC provides an annual source of funds to DOJ and OIG to cover a portion of their costs in fighting health care fraud through the enforcement of the FCA. HCFAC established a special expenditure account with annual appropriations from the Medicare Hospital Insurance Trust Fund (MTF). Funds are disbursed annually from this account to various divisions in DOJ and HHS to fund their anti-fraud activities.²

DOJ Costs in Fighting Health Care Fraud

The first step in the estimate of costs is to determine the budget for the activities in DOJ that are directly involved in fighting fraud and generating recoveries. Two components of DOJ meet these criteria—the civil fraud enforcement activities of the Civil Division and the civil fraud litigation activities of the USAOs.

CIVIL DIVISION'S COSTS. The Civil Division of DOJ is estimated to have spent a total of \$73.8 million on civil health care fraud enforcement between 1997 and 2001.

Table 1 shows the figures for each year over the 1997-2001 period. We assume that 65 percent of the total amount spent on civil fraud (FCA) enforcement is spent on health care fraud activities because that is the average proportion of recoveries accounted for by health care settlements. This yields an amount of \$73.8 million for the Civil Division's cost in fighting *health care fraud*.

USAOs' COSTS. Most USAOs have an Affirmative Civil Enforcement (ACE) unit in their General Civil Litigation section that investigates and prosecutes civil FCA cases. Civil *fraud* litigation is not their only area of work, however, and there are clearly cases outside of the health care field.

To estimate the USAO costs attributable to combating health care fraud, we begin with the total USAO budget over the five-year period. This amount is \$5.611 billion. On average, 22 percent of the budget went to Civil Litigation over this period. Applying this percentage to the whole budget yields an estimate of \$1.234 billion for civil litigation by USAOs over these five years.

The next step is to estimate how much of this amount goes for civil *fraud* litigation. To obtain this estimate, which does not appear

²Meyer, Jack A. and Stephanie Anthony, *Reducing Health Care Fraud: An Assessment of the Impact of the False Claims Act*. September 2001.

Table 1 DOJ/Civil Budget for Civil Health Care Fraud Enforcement

	Fiscal Years					5-yr Total
	1997	1998	1999	2000	2001	
Amount spent on civil health care fraud enforcement (in millions)	\$7.1	\$14.3	\$17.7	\$17.2	\$17.5*	\$73.8

*The figure for 2001 is a New Directions for Policy estimate.

Source: DOJ/Civil Division. These numbers reflect attorneys' salaries, experts and litigation for civil fraud, multiplied by 0.65.

in budget figures, we interviewed several U.S. Attorney's offices. Amalgamating their estimates yielded an approximate figure of 26 percent of the salaries and related litigation costs of USAOs' Civil Litigation staff that is dedicated to *civil fraud litigation* (which, according to the USAOs, is virtually 100 percent FCA enforcement). This yields a dollar amount of \$320.9 million for the civil fraud budget of the USAOs over the 1997–2001 period. Again, assuming 65 percent of this amount is for health care fraud, we estimate that \$208.6 million is the amount devoted to the USAO activities in fighting *health-care related civil fraud* (see Table 2).

OIG Costs

We now turn to estimating the costs associated with civil fraud incurred at the Office of the Inspector General at HHS. With the assistance of OIG, we estimated the portion of their activity that could be attributable to *civil health care fraud* enforcement. The Department provided data on costs related to civil health care fraud incurred in three areas: (1) the Office of Investigations; (2) the Office of Audit Services; and (3) the Office of Evaluations and Inspections. OIG calculated the number of hours of work that their staff in that each of these divisions devoted to civil health care fraud enforcement, and also provided us with fully loaded hourly rates of compensation reflecting not only salaries but also employee benefits and overhead.³ Using these figures, we determined total costs for each group of OIG employees in fiscal year 2001, as shown in Table 3.

The next step is to compare this figure of \$8.3 million to the total HCFAC allocation to OIG for 2001, which is \$130 million. Thus, we estimate, using OIG figures, that 6.4 percent of the OIG HCFAC

³In calculating the staff and related costs attributable to civil health care fraud enforcement, OIG excluded certain cost items that are not relevant to our inquiry. These include criminal cases, employee misconduct cases, and grant fraud cases. Note that in some cases tracked as criminal cases, OIG staff may simultaneously be working on the civil fraud implications. OIG also excluded hours of work related to civil health care fraud undertaken in the general counsel's office.

Table 2 Amount Devoted to the USAO Activities in Fighting Health-Care Related Civil Fraud, Fiscal Years 1997–2001

	Fiscal Years					5-yr Total
	1997	1998	1999	2000	2001	
USAOs Costs (in millions)	\$37.0	\$38.7	\$42.2	\$43.7	\$47.0	\$208.6

Source: U.S. Department of Justice, U.S. Attorney's: Ten-Year Display of Budget Authority and Positions, 1995-2004. These numbers were calculated using the annual budget authority multiplied by 0.22. This number was then multiplied by 0.26. This number was then multiplied by 0.65, as described above.

Table 3 OIG Costs Related to Civil Health Care Fraud Enforcement, Fiscal Year 2001

Office	Costs (in millions)
Office of Audit Services	\$4.98
Office of Investigations	\$3.32
Office of Evaluation and Inspections	\$.002
Total	\$8.302

Source: OIG, HHS

allocation in fiscal year 2001 was devoted to civil fraud health care fraud enforcement.

Since we do not have corresponding data on the OIG outlays related to civil fraud enforcement for earlier years, we make the simplifying assumption that this ratio held constant over the period. While this may be imprecise in either direction, the approximate order of magnitude is likely to be correct as there does not appear to be any dramatic change in the way OIG went about its work in this area over the period of time covered by our study. Table 4 shows that OIG's costs for civil health care fraud enforcement totaled \$32.8 million over five years.

TOTAL FEDERAL GOVERNMENT COSTS. We now sum the costs from both DOJ and OIG to arrive at total federal government costs for each of the five years in our study period. Table 5 shows that total outlays for civil health care fraud enforcement over five years were \$315.2 million.

Benefit/Cost Ratio

We can now calculate the benefit/cost ratio. To capture the government's net benefit, we need to first remove the portion of the health-related FCA recoveries paid to relators in *qui tam* cases. According to DOJ data, relators were paid \$345.5 million in health-related civil fraud cases between 1997–2001.⁴ Thus we remove \$345.5 million from the health-related civil fraud recoveries of \$3.1 billion. Therefore, the total amount of the recoveries being returned to the government is \$2.75 billion.

Table 6 shows that the ratio of the federal government's direct ben-

⁴ The 1997–2001 figures were taken from the Monetary Results section of The Department of Health and Human Services and The Department of Justice. Health Care Fraud and Abuse Control Program Annual Reports for 1997–2001.

Table 4 OIG Costs Attributable to Civil Health Care Fraud, 1997–2001 (in millions)

	Fiscal Years					5-yr Total
	1997	1998	1999	2000	2001	
OIG Outlays for Civil Health Care Fraud	\$5.1	\$5.5	\$6.3	\$7.6	\$8.3	\$32.8

Source: OIG, HHS. The numbers shown above for each year reflect 6.4 percent of the HCFAC allocation for that particular year.

Table 5 Federal Outlays for Civil Health Care Fraud Enforcement, 1997–2001 (in millions)

	Fiscal Years					1997–2001
	1997	1998	1999	2000	2001	
DOJ Civil	\$7.1	\$14.3	\$17.7	\$17.2	\$17.5	\$73.8
USAO	\$37.0	\$38.7	\$42.2	\$43.7	\$47.0	\$208.6
OIG Outlays for Civil Health Care Fraud	\$5.1	\$5.5	\$6.3	\$7.6	\$8.3	\$32.8
Total	\$49.2	\$58.5	\$66.2	\$68.5	\$72.8	\$315.2

efits from civil health care fraud enforcement to its costs is 8.7 to 1.

As a result of the higher stakes for health care companies, many firms have become far more vigilant about their internal operations in an effort to comply with the law. Our earlier study concluded that firms are less likely to threaten and intimidate employees who detect apparent fraudulent billing practices now that they are aware that such employees could become whistleblowers and be protected from corporate retaliation. Administrative remedies are frequently implemented by OIG in conjunction with FCA investigations and settlements pursued by DOJ. One important area of collaboration between the two federal agencies involves Corporate Integrity Agreements (CIAs). These agreements are developed jointly by OIG and the companies alleged to have committed fraud during FCA settlement negotiations. CIAs are now part of most FCA settlements.⁵

During the course of our work on our in-depth study of health care fraud, we uncovered many examples of the “deterrent effect” emerging from the combined activities of the federal government. In addition to the CIAs, many of the consulting firms apparently switched from advising companies how to “beat the system” to advising them on how to comply with the letter of the law and stay out of trouble.

⁵Meyer and Anthony, op. cit.

Table 6 Benefit-Cost Ratio, FYs 1997–2001

	Benefits ^a	Costs ^b	Benefit-Cost Ratio
Estimate	\$2.75 billion	\$315.2 million	8.7:1

^a See Figure 4. 1997–2001 Total. ^b See Table 5

These indirect effects of the FCA’s potentially large settlements and its whistleblower provisions are important. If a large settlement agreed to by *one company* not only changes its behavior in the future, but also has a sentinel effect that changes behavior throughout the industry, then the ripple effect of the FCA is very widespread. The indirect effects, which cannot be measured accurately at this time, may be a substantial multiple of the direct, measurable benefits in the form of monetary recoveries.

Conclusions and Recommendations

The U.S. taxpayers are getting an excellent return on their dollars invested in fighting fraud against the Medicare program. Our findings show that for every dollar spent to investigate fraud, recover funds obtained through illegal billings, and prosecute these civil cases, nearly nine dollars are received in return. This order of magnitude of the rate of return on the government’s investment makes this area of government expenditures unusual, if not unique. Civil health care fraud is surely one area of the federal budget where the government is running a substantial “surplus.”

The benefit/cost ratio of nearly nine to one is likely to be an underestimate of the real return that the taxpayers are receiving on outlays for civil health care fraud enforcement. The indirect benefits associated with deterrent effects, described earlier, undoubtedly add substantially to the public’s benefit.

The government must use its authority with both vigor and caution. The whistleblower and penalty provisions of the law should be retained in order to provide the federal government with the assistance it needs to uncover fraud and the clout it requires to recover stolen funds. But it must also respect the rights of companies in the health care industry, continue to promote corporate agreements that deter fraud at the front end, and distinguish carefully between honest billing errors and fraud.

If the provisions of the FCA are enforced in this fashion, the Act will continue to save large amounts of money and contribute to the fiscal viability of the Medicare program.

**Taxpayers Against Fraud
Education Fund**

1220 19th Street, NW
Suite 501
Washington, DC 20036
202-296-4826
www.taf.org