GAO

United States
General Accounting Office
Washington, D.C. 20548

Accounting and Information
Management Division

B-277134

August 1, 1997

The Honorable David E. Skaggs
House of Representatives

Subject: Inspector General: Information on Resources and Planning at the Department of Health and Human Services

Dear Mr. Skaggs:

This is in response to your request for certain information on the operations of the Department of Health and Human Services (HHS) Inspector General (IG). Specifically, you asked for information on the decline in IG investigative resources and on other federal and state actions designed to improve health care fraud investigative and enforcement activities.

RESULTS IN BRIEF

During February 1993, the IG began implementing a strategic plan developed by its Office of Investigations to address budget limitations and investigative staff reductions and to help it continue to fulfill its investigative responsibilities. The plan focused investigative resources on states that received the most HHS money. As of February 1997, the IG's Office of Investigations had 237 staff located in 27 states, the District of Columbia, and its headquarters office. (See table 1 and figure 1, respectively.)

In the past few years, several actions have been taken to improve health care fraud investigative and enforcement activities across the country. Operation Restore Trust, which began in 1995 as a 2-year demonstration program and was extended in 1997, is a collaborative federal and state effort to fight fraud, waste and abuse in selected health care areas. Further, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, calls for the HHS Secretary, acting through the HHS IG, and the Attorney General to establish a health care fraud and abuse control program. This program is intended to, among other things, coordinate federal, state, and local law enforcement programs to control fraud and abuse in health plans, and to conduct investigations and other actions relating to the delivery of and payment for health care. Using its $27 million budget increase over fiscal year 1996, the

IG plans, in part, to increase investigative staff by approximately 60 in fiscal year 1997. The budget increase resulted from $70 million provided by HIPAA for health care-related fraud and abuse efforts and a $43 million decrease in the IG's discretionary budget. If the IG receives the maximum amount of funding permitted under HIPAA after fiscal year 1997, the IG plans to have investigators in almost all states by the year 2002. Finally, other federal and state organizations, such as the Federal Bureau of Investigation and State Medicaid Fraud Control Units, participate in efforts to reduce health care fraud, and the Health Care Financing Administration has begun an effort to improve the Medicare claims processing system.

SCOPE AND METHODOLOGY

To obtain information on the decline in HHS IG investigative resources, we

- reviewed IG strategic plans, resource allocation strategies, and other documentation to identify the IG's nationwide investigative staff levels and investigative plans, and

- interviewed IG officials to further understand the strategic plan.

To identify actions to improve health care fraud investigative and enforcement activities, we

- obtained IG and other documents to identify IG and other organization health care fraud investigative plans and activities, including those for implementing the joint HHS and Department of Justice fraud and abuse control program required by HIPAA, and

- interviewed IG officials to obtain an understanding of current and planned health care fraud investigative and enforcement improvement activities.

We primarily used IG-prepared documents in compiling the information contained in this report. We reviewed and compared these documents to ensure that they were consistent in their treatment of, and comments on, investigative staffing issues and the need for, and implementation of, the IG's strategic plan. In general, we did not independently verify the information contained in these documents. We conducted our review from March through June 1997 in accordance with generally accepted government auditing standards. We provided a draft of this report to IG officials and have incorporated their views where appropriate.

BACKGROUND

When the HHS IG was established in 1976, field investigators from throughout HHS became the nucleus of the IG's Office of Investigations. Staff size increased as the number of complaints of program fraud grew and as a result of 1982 and 1983 actions that transferred personnel from the Social Security Administration and the Health Care Financing Administration to the IG. Most investigators were located in field offices throughout the nation.

Over the years, the focus and scope of IG operations expanded and adjusted to meet emerging patterns of program fraud and abuse. For example, the strategic plan noted that, as health care costs increased in the 1980's, the IG shifted resources to this area. Pressure for investigative assistance also resulted from problems in certain areas, such as the use of false Social Security numbers.

IG STRATEGIC PLAN

In February 1993, the Inspector General began implementing a strategic plan developed by its Office of Investigations to address budget limitations and investigative staff reductions and to help it continue to fulfill its investigative responsibilities. The plan noted that the problem of an increasing workload due to health care and Social Security program growth and decreasing resources had to be resolved or at least mitigated. It also recognized that "[a]ny resolution [to the problem] will involve some sort of cut, or reduction, in costs or coverage." Further, the plan noted that, to absorb the extra personnel-related costs caused by mandated salary and locality pay increases, the IG would not fill vacated positions.

According to the strategic plan, the IG considered several alternative actions before selecting one. The plan acknowledged the need for reductions in caseloads, geographic deployment of staff, and program coverage. The alternative selected concentrated the IG's investigative resources in the geographic and program areas where the IG felt that it could have the greatest impact–generally, those states that received the most HHS money. The plan called for some regional realignments to reduce travel costs and to improve management efficiency and investigative coverage. Further, except under special circumstances, the IG would generally not open new investigations in states with no investigative office or in states that received the lowest amounts of HHS money. The plan also called for the continuation of training, promotions, and other items that would have been cut under other alternatives considered.

Under the plan, the IG would also increase the number of health care fraud referrals it made to other federal and state organizations, such as the Federal

Bureau of Investigation, the United States Postal Service, and State Medicaid Fraud Control Units. These referrals typically related to situations where providers bill (1) for services not rendered, (2) for unnecessary services, and (3) at rates higher than those allowable for the services rendered.

OFFICE OF INVESTIGATIONS NATIONWIDE STAFFING

As of February 1997, the IG's Office of Investigations had 237 investigative staff located in 27 states, the District of Columbia, and in its headquarters office, as shown in table 1.

Table 1: IG Investigative Staff Levels, By Location, in February 1997

Location	Office of Investigations Staff as of February 1997
Alabama	2
Arizona	2
Arkansas	2
California	31
Colorado	4
Connecticut	1
District of Columbia	5
Florida	17
Georgia	12
Illinois	17
Indiana	2
Kentucky	1
Louisiana	2
Maryland	5
Massachusetts	12
Michigan	3
Minnesota	3
Missouri	2
New Jersey	3
New York	24
North Carolina	2
Office of Investigations-Headquarters	39
Ohio	4
Oregon	2
Pennsylvania	14

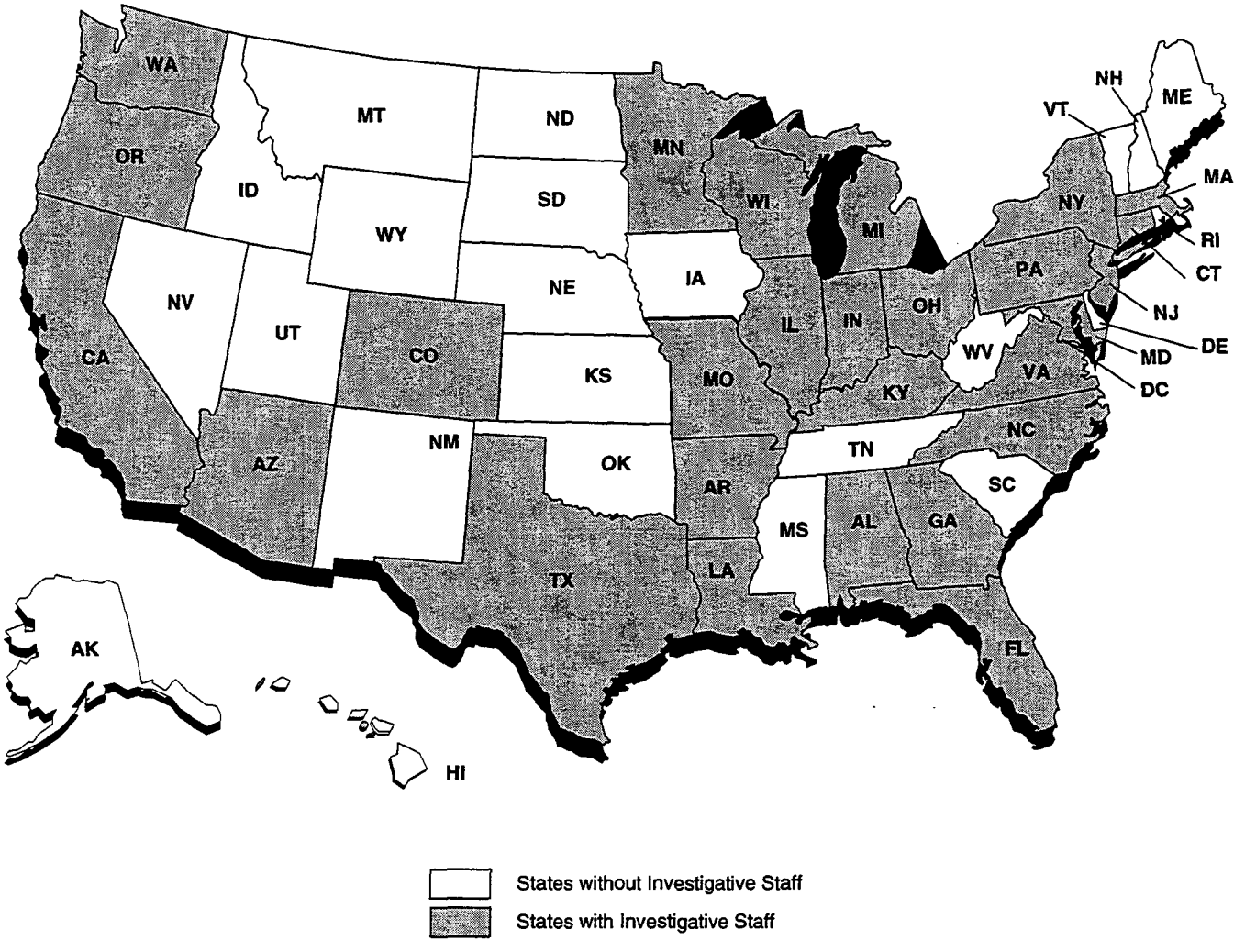
Location	Office of Investigations Staff as of February 1997
Texas	18
Virginia	2
Washington	2
Wisconsin	4
Total	237

Source: HHS Inspector General. We did not independently verify this information.

Figure 1 identifies, geographically, the 27 states with investigative staff and the 23 with none as of February 1997. The strategic plan stated that the IG would focus investigative staff in states that received the most HHS money. Based on information provided by the IG, the 23 states with no investigative staff received about 12 percent of the total fiscal year 1993 (the year the IG began implementing its strategic plan) HHS money received by states.[1]

[1]In 1994, the Social Security Administration (SSA) became an independent federal agency. We excluded SSA money from HHS money received by states in calculating the percentage of monies received by states because of the transfer of SSA-related activities and staff from HHS to SSA.

Figure 1: Nationwide Investigative Staff Allocation as of February 1997



Source: HHS Inspector General. We did not independently verify this information.

RECENT FRAUD INVESTIGATIVE AND ENFORCEMENT ACTIVITIES AND INITIATIVES

In the past few years, several federal, state and local governments have taken actions to strengthen health care fraud investigative and enforcement activities. These include the initiation of the Operation Restore Trust program, the passage of the Health Insurance Portability and Accountability Act of 1996, health care fraud activities by other federal, state, and local organizations, and HHS efforts to improve its Medicare claims processing systems.

Operation Restore Trust

In March 1995, the HHS IG initiated Operation Restore Trust as a 2-year demonstration program in which federal and state agencies joined to fight fraud, waste, and abuse in home health agencies, nursing homes, and the medical equipment and supply industry. This program targeted five States (New York, Florida, Illinois, Texas, and California) which accounted for 40 percent of the nation's Medicare and Medicaid beneficiaries. According to the IG, as of May 20, 1997, this 2-year demonstration program (1) incurred total spending of $7.9 million and identified $187.5 million in program savings resulting from restitutions, fines, settlements, and other identified overpayments, and (2) resulted in 74 convictions, 58 civil actions, and the exclusion of 218 providers from participation in Medicare and Medicaid for various periods of time. In addition, the IG issued 47 audit and inspection reports related to Operation Restore Trust and had another 31 audits and evaluations underway. Finally, we were advised that a hotline the IG established in 1995 under the Operation Restore Trust program had received about 13,000 calls and letters relating to problems in HHS programs.

On May 20, 1997, the HHS Secretary announced that Operation Restore Trust would be extended beyond its 2-year demonstration period. Initially, it is to be expanded into 12 new states--Arizona, Colorado, Georgia, Louisiana, Massachusetts, Missouri, New Jersey, Ohio, Pennsylvania, Tennessee, Virginia, and Washington. The Secretary noted that, over the longer term, the techniques developed through Operation Restore Trust are to be applied in Medicare and Medicaid program areas in all 50 states.

Health Insurance Portability and Accountability Act of 1996

The Health Insurance Portability and Accountability Act of 1996 is intended to combat waste, fraud, and abuse in health insurance and health care delivery. It calls for the establishment of a fraud and abuse control program to

- coordinate federal, state, and local law enforcement programs to control health plan fraud and abuse;
- conduct investigations, audits, evaluations, and inspections of the delivery of and payment for health care in the United States;
- facilitate the enforcement of health care fraud and abuse statutes;
- provide for the modification and establishment of safe harbors and the issuance of advisory opinions and special fraud alerts; and
- provide for the reporting and disclosure of certain final adverse actions against health care providers, suppliers, or practitioners.

HIPAA provides HHS and the Department of Justice with funding to combat health care fraud and abuse. The IG receives some of this funding. For example, its gross budget authority increased from $89 million for fiscal year 1996 to an estimated $116 million for fiscal year 1997. This $27 million net increase resulted from $70 million provided by HIPAA for health care-related fraud and abuse efforts and a $43 million decrease in the IG's discretionary budget. HIPAA provides increasing amounts of funding for the IG for fiscal years 1998 through 2003, and level funding of between $150 million and $160 million per year, thereafter.

IG officials told us that they will use the fiscal year 1997 budget increase, in part, to increase overall investigative staff by about 60 individuals. The IG now plans to have investigative staff in almost all states by the year 2002. Specifically, it plans to staff new investigative offices in 35 states and San Juan, Puerto Rico, during a 7-year 6-phase program starting in fiscal year 1997. According to IG officials, these planned actions are based upon the assumption that the IG will receive the maximum amount of funding available under HIPAA. Documents provided by the IG show that 23 of these states were the ones that had no investigative staff in February 1997 as shown in figure 1. As of June 1997, the IG had assigned investigative staff to new offices in 6 of the 35 states.

Four of these 6 states were among those that had no investigative staff as of February 1997.

Other Federal and State-Level Health Care Fraud Efforts

As mandated by HIPAA, the HHS Secretary and the Attorney General issued Health Care Fraud and Abuse Control Program and Guidelines, effective January 1997. The guidelines, in part, outline the responsibilities of the fraud and abuse control program at the federal, state, and local law enforcement agency levels. In addition to HHS, federal organizations involved in the program include:

- the Federal Bureau of Investigation, which focuses on fraud in private health plans and on any health plan receiving federal funds including Medicare, Medicaid, and the Federal Employees Health Benefits Program;

- the IG, Defense Criminal Investigative Service, Department of Defense, which investigates fraud and abuse in health care programs for active duty and retired military personnel, their dependents and survivors;

- the Department of Veterans Affairs IG, which focuses on fraud relating to health care for veterans; and

- The Department of Labor IG, which investigates health care fraud in major federal health benefit and disability programs administered by the Department that compensate or provide benefits to federal workers, coal miners, and longshore/harbor workers.

At the state level, organizations involved in the program include:

- the State Medicaid Fraud Control Units that investigate and prosecute (1) criminal violations of state laws regarding Medicaid program fraud, and (2) patient abuse and neglect in Medicaid-funded facilities,

- State Attorneys General that investigate health care fraud offenses under state law, and

- State survey and certification agencies that monitor quality of care in long-term care facilities.

In addition, private health plans investigate allegations of fraud related to specific private plans.

According to the National State Auditors Association's Auditing in the States: A Summary (1996 Revision), (1) almost all states have audit agencies that have the authority to investigate fraud, waste, abuse, or illegal acts, (2) audit agencies in 31 states can issue subpoenas, and (3) 16 state audit agencies operate hotlines to allow citizens to report perceived instances of fraud, waste, abuse, or illegal acts.

Health Care Systems Upgrades

In another area, the Health Care Financing Administration (HCFA), the HHS organization that runs the Medicare and Medicaid programs, is attempting to upgrade its Medicare claims processing system–the Medicare Transaction System (MTS)–by replacing nine separate automated information systems with a single, unified system. The new system is intended to improve customer service, reduce operating expenses, provide more effective control over claims processing, provide better oversight of contractors, provide for substantial administrative savings, and better protect program funds against waste, fraud, and abuse. In a May 1997 report and testimony,[2] we noted that, despite much hard work and some progress, critical weaknesses–both managerial and technical–continued to exist. These weaknesses call into serious question whether MTS, without significant change, will be able to perform as required. Our report includes 20 major recommendations to help HCFA enhance the likelihood of acquiring the kind of system it must have, in a cost-effective manner.

AGENCY COMMENTS

We provided a draft of this report to HHS IG officials. The officials agreed with the information presented, and their views have been incorporated where appropriate.

- - - - -

[2]Medicare Transaction System: Success Depends Upon Correcting Critical Managerial and Technical Weaknesses (GAO/AIMD-97-78, May 16, 1997); and Medicare Transaction System: Serious Managerial and Technical Weaknesses Threaten Modernization (GAO/T-AIMD-97-91, May 16, 1997).

We are sending copies of this report to the Secretary of the Department of Health and Human Services, the Attorney General, the Inspector General of the Department of Health and Human Services, the Office of Management and Budget, and other interested parties. Copies will be made available to others upon request. If you or your staff have any questions about our work, I can be reached on (202) 512-3029.

Sincerely yours,

Theodore C. Barreaux
Associate Director, Audit Oversight and Liaison

(911742)