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LITIGATION AND ENFORCEMENT

Whistleblowers

Merena & Partners Win $52 Million; Judge Breaks New Ground on Qui Tam Issues

Three whistleblowers are entitled to a share of nearly all the government's settlement with SmithKline Beecham Labs – producing an award of $52 million – the U.S. District Court for the Eastern District of Pennsylvania ruled April 8 in a decision breaking new legal ground on the False Claims Act (FCA) provisions that govern qui tam relators and their share of the government's damages. (**U.S. ex rel. Merena v. SmithKline Beecham Corp.**, E.D. Pa., #93-5974, 4/8/98)

Most importantly, Senior Judge Donald W. VanArtsdalen ruled that the FCA's relator award provisions for cases in which the Justice Department intervenes do not – as many people have long assumed – essentially provide for a "finder's fee" on claims in which the government does most of the work of developing a case for negotiation or trial. Rather, under the statute the relator earns a share simply by "substantially contributing" to the government's development of the case, VanArtsdalen held.

The primary issue he addressed was whether the three relators (former SmithKline payment receiving supervisor Robert Merena, Dr. Charles Robinson and attorney Glenn Grossenbacher) could participate in the roughly four-fifths of the SmithKline settlement that the government attributed to "automated chemistry" (AC) tests. The government argued that none of the relators alerted it to SmithKline's AC activities, because it had already convicted National Health Labs of similar charges and had subpoenaed SmithKline on the matter before Merena contacted the government (**MHFM**, 4/6, p. 2). VanArtsdalen called this argument "irrelevant," saying "I find nothing in the statute that states or suggests that merely because the Government is carrying out an investigation, a qui tam action is barred."

Widespread publicity, predating a relator's suit, about a defendant's wrongdoing is also irrelevant, said VanArtsdalen.

Forcing Earlier Litigation?

In a 75-page opinion with few legal cites, VanArtsdalen relied on his own reading of the FCA and noted many issues on which the statute is silent. In so doing, he may have forced the government and relators to litigate, or at least to formally clarify, their relationship in the sealed complaint stage – perhaps before they have information on all relevant issues.

In addition to his "finder's fee" ruling, VanArtsdalen issued two other major legal rulings. First, he held that the government could not raise the issue of prior public disclosure, a jurisdictional matter under the statute, because the relators' complaint against SmithKline had been dismissed with prejudice by consent of all parties in the February 1997 final settlement with the firm. He reasoned that since the complaint was dismissed with jurisdiction retained only to determine relator shares and enforce the settlement, a jurisdictional argument was foreclosed.

Thus, he ruled that he still had jurisdiction to rule on relator shares, but not on public disclosure, a major statutory qualification for such shares. He thereby dodged the major factual and legal questions the parties had presented on the AC dispute.

Second, VanArtsdalen ruled that a relator can partake of an FCA settlement between the government and a defendant on all the issues the government raised, even if the relator did not raise all the issues. He gave several reasons for the ruling: (1) legally, the statute "makes no mention of treating a qui tam complaint as having distinct and divisible claims . . . . The statute speaks of the action and claim as a single unit or whole entity"; (2) legally, as noted above, the statute hinges relator awards simply on "substantially contributing" to the government's case, not to particular issues in that case; and (3) factually, he found that the settlement with SmithKline was for a lump sum on all issues. In fact, he rejected outright the government's claims on the dollar value of the AC issues within the overall settlement.

Notably, the relators did not argue for any of the three major rulings above. Instead, they argued that factually and legally they met all the statute's requirements for an award, such as lack of public disclosure.

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The implication of VanArtsdalen's three major legal rulings would seem to be to force the government and relators to litigate or clarify their relationship much earlier in the proceedings, defining the relator share or at least the recoveries in which the relator can participate before the settlement.

It is not uncommon today to decide the relator's share after dismissing the defendant, and to calculate the share issue by issue.

In this case, the government did not read Merena's original complaint as substantially raising AC issues, and Merena's amended complaint was dismissed in the settlement without ever having gone into formal discovery. Yet, VanArtsdalen indicated that if the government was going to deny Merena's participation in AC recoveries, it had to have done so as part of the settlement.

His other legal rulings were that:

- There was no problem with Grossenbacher and Robinson filing after Merena, despite VanArtsdalen's own ruling last summer in a related case finding a "first to file" requirement in the statute. Also, there was no problem with Justice having to address the merits of all three of their complaints as a unified whole.
- The relators did not waive their right to challenge Justice's proposed shares because even if he found that the relators were aware that Justice intended to cut them out of shares on what it calculated were the AC parts of the settlement -- he found just the oppositie -- it was expressly provided in the SmithKline settlement that relator shares were yet to be determined.
- The relators could not partake of Medicaid recoveries because they were expressly provided in the February 1997 settlement.
- "Risk and hazard to occupational reputation and future employment prospects" are irrelevant under the statute in determining relator share.
- Under § 3730(d) of the statute, a relator who "substantially contributes" to the government's case may partake in a settlement in the 15%-25% range, regardless of the vague standards in the same subsection for 0%-10% participation.

Factual Issues

The parties tentatively settled in the fall of 1996, when SmithKline put $325 million in escrow. By February 1997, that had grown to $334 million. After subtracting the Medicaid recoveries and an amount accounted for in a settlement with a fourth relator, approximately $306 million of the SmithKline recovery remained at issue. VanArtsdalen ruled that 17%, or $52 million, was the appropriate share. The government already paid $10 million on non-AC issues on which it acknowledged that Merena was the "finder" (**MHFM**, 3/23, p. 3), so VanArtsdalen ordered it to pay $42 million more. $52 million is more than twice as much as all 94 U.S. Attorney's Offices have this year to address health fraud (see article, p. 8). The 17% share applies both to issues of which Merena was the finder and those of which he was not.

VanArtsdalen decided every factual issue except on the Medicaid participation dispute in favor of the relators. This included narrow issues such as finding that Justice conceded that Merena raised AC issues in his original complaint, when the department had conceded only a passing, generalized reference.

On the key issue of the relators' contribution, he lauded Merena's and Robinson's efforts to help the government's case. He found an internal Justice Department dispute, between the Philadelphia people and the Washington and San Diego people over who contributed most to the SmithKline/AC settlement, was a fundamental factual issue and he found for Merena and the Philadelphia people on it.

Marc Raspanti and **David Laigaie** of Miller, Alfano & Raspanti in Philadelphia represent Merena. **John Clark** of Goode, Casseb & Jones in San Antonio represents Robinson and Grossenbacher. **Russell Kinner** of the Justice Department civil division in Washington represents the government.

A Justice spokesman said the department is reviewing its appeal options. It has at least 60 days to notice an appeal.

VanArtsdalen retired after issuing this ruling. Thus, if the case is ever remanded, a new judge will probably have to address it. ■

Hospitals/Lab Servies

"Bad Bundle" Nets $4M in Ohio; Edits Are a Key Issue in Florida; DOJ Softens National Approach

Fourteen Ohio hospitals paid a total of $4.2 million over the last several months to settle Operation "Bad Bundle" charges, while in Florida issues have arisen over computer "screens" that Blue Cross put in to catch unbundling. In Washington, DC, DOJ's top health fraud official indicated a change in the initial approach that Justice may take toward hospitals.

Bad Bundle is a joint project of HHS/OIG and the Justice Department focussed mainly on alleged failures by hospitals to bundle certain outpatient chemistry tests for billing purposes (**MHFM**, 3/9, p. 3, and 1/26, p. 7).

Ohio. The Ohio hospitals generally settled for "double damages," or amounts twice the government's overpayment, said AUSA **Mark T. D'Alessandro** of the Southern District of Ohio, who handled the case along

with the Chicago HHS/OIG office under Regional IG **Michael T. Dyer**. The cases were settled without litigation or sanctions. Compliance plans with revised billing systems -- but not corporate integrity agreements -- were required.

While there were issues of double-billing and lack of medical necessity in the case, the large majority of claims concerned unbundling, said D'Alessandro. Claims arose from Medicare, Medicaid and TRICARE.

The largest exposure was Good Samaritan Hospital in Dayton for $1.1 million. Other hospitals in the Southern District are still negotiating, D'Alessandro said.

Florida. Florida hospitals have not received any new settlement demands since they told the government last fall that their Medicare carrier, Blue Cross and Blue Shield of Florida, had installed edits in the first half of 1992 that automatically bundle unbundled lab billings.

Edward Hopkins of Steel, Hector & Davis in West Palm Beach said that the Blue Cross edits were believed to be effective in cutting out unbundled claims, and thus may have sharply reduced the government's potential claims. There were only three or four months in early 1992 for which the government was making claims but on which the edits were not in place, Hopkins said. The screens developed by the Blues in Florida were used by Medicare carriers in other states, he added.

William Bell, general counsel of the Florida Hospital Association in Tallahassee, said the Justice Department sent letters early last summer raising the bundling issue to about a dozen hospitals in the Southern District of Florida. No letters have yet been sent in the Middle or Northern Districts, Bell said. The hospitals informed the government of the Blue Cross edits in August. No further letters raising the issue have been sent since October, he said.

The letters did not propose settlement figures, but asked the hospitals to do self-audits, said Hopkins, who represents several hospitals on the matter. His clients proposed work plans last October and November for audits ranging in cost from $15,000 to $80,000. The government has not yet replied to those proposals, he said.

"The parties must agree on the scope and methodology of the audit [before it is begun] or we'll end up arguing on the results," he said. The government has approved study plans in advance in other districts, he said. The cost of some audits may exceed the damages in light of the Blue Cross screens, he suggested.

AUSA **Sally Richardson** in Miami, who is handling the case, said the government has an auditor reviewing the work plans and that the hospitals will then be expected to do the audits. Any "corrections" due to the Blue Cross screens have not stopped the effort, she said, and damage issues are premature until the audits are finished.

National. Main Justice is giving U.S. Attorney's Offices (USAOs) a second way to contact hospitals and initiate a Bad Bundle case or other general audit issue, said **John T. Bentivoglio**, who works in Deputy Attorney General Eric Holder's office as the overall supervisor of the Department's health fraud fighting efforts.

Bentivoglio, who made the announcement April 9, said USAOs could in their own discretion use "contact letters," which would invite hospitals to talk to the government about possible False Claims Act liability. Many letters starting Bad Bundle probes have been "demand letters," taking a more assertive and directive tone.

A letter to USAOs on contact letters will be sent soon, Bentivoglio said. Other audits on which contact letters could be used are Physicians at Teaching Hospitals (PATH), 72-Hour Window and DRG Upcoding. ■

Federal Cases

CALIFORNIA/Medical Practice -- A Los Angeles doctor was indicted April 9 on 41 felony counts that can only be described as "multi-discliplinary" to match the range of the defendant's alleged activities. (**U.S. v. Perry**, C.D. Calif., 4/9/98)

Keith O'Neil Perry was accused of:

- Operating two clinics in the name of a straw owner to obtain Medicare/Medicaid provider numbers after brushes with the law in 1992.
- Going bankrupt six times, and not revealing in bankruptcy petitions that he had Medicare/Medicaid money in an out-of-state bank account.
- Tax evasion for failure to pay employment taxes.
- Falsely certifying the need for lymphedema pumps.
- Falsely certifying the need for home health services, thereby supporting $5 million in false claims to Medicare; and receiving kickbacks for the certifications.
- Defrauding a bankruptcy receiver.

AUSAs **Steven Linick** and **Paul Rochmes** are handling the case.

NEW YORK/"Granny's Advisor Law" -- A provision of the Balanced Budget Act of 1997 (§ 4734; 42 U.S.C. § 1320a-7b(a)(6)) that made it a crime to "counsel or assist" people to dispose of assets to become eligible for Medicaid is unconstitutional as a deprivation of lawyers' rights to free speech in counseling their clients, the U.S. District Court for the Northern District

of New York held April 7. (**New York State Bar Association v. Reno**, N.D. N.Y., #97-CV-1768, 4/7/98)

Chief Judge Thomas J. McAvoy said the government did not contest that proposition, but opposed an injunction against the law on the ground that Attorney General Reno had issued a directive March 11 that the government would not enforce the law. McAvoy found this unsatisfactory because, among other reasons, lawyers are duty-bound to follow the law. He entered a preliminary injunction against the government enforcing the law.

Robert Witmer and **Daniel Hurteau** of Nixon Hargrave Devans & Doyle in Rochester, NY, represent the New York State Bar Association. **Sheila Lieber** and **Eric Angel** of the Justice Department civil division in Washington, DC, represent the government.

SOUTH CAROLINA/Chiropractic – A medical doctor, David Prater Willett, pled guilty March 31 to two counts of mail fraud and aiding and abetting private insurance fraud for certifying test interpretation documents as part of a scheme to expand the billings of several chiropractic clinics. (**U.S. v. Willett**, D. S.C., 3/31/98)

The chiropractor operating the clinics, John Gregory Osteen, pled guilty in February (**MHFM**, 3/9, p. 5). An integral part of the scheme was having a medical doctor certify the test results to avoid Blue Cross limits on reimbursement to chiropractors.

AUSA **Stanley Ragsdale** is handling the case.

OHIO/Neurology – A Youngstown neurologist was charged with one count of mail fraud in an information April 13 for conducting more than $100,000 worth of medically unnecessary needle electromyographies. (**U.S. v. Afrooz**, N.D. Ohio, 4/13/98)

The State of Ohio revoked the medical license of Nader Afrooz, 64, in March. AUSA **Ann C. Rowland** handled the case. ■

INVESTIGATIONS AND COMPLIANCE

Anti-Fraud Programs

HCFA Starts Work on MIP Contracting Program

Hundreds of potential contractors converged on HCFA's offices in Baltimore April 17 to learn more about the agency's effort to create a new class of Program Safeguard Contractors, or PSCs, for its Medicare Integrity Program (MIP) launched in HIPAA.

Three hundred seventy-one contractors and other professionals expressed interest in the conference on the HCFA Web site. These included nearly all the 72 current Part A intermediaries, and Part B, home health and medical equipment carriers; health business consultants large and small, many presumably hoping only for subcontracts; providers; health plans and insurers; and many others.

A "strategy fact sheet" said HCFA had two basic -- and potentially contradictory -- policies: to change the integrity contractors from the 72 now handling Medicare claims to a "broader" contractor community selected through competitive procedures; and to reduce to a "much smaller number" the general MIP contractors. HCFA said it intends to let the first of new PSC contracts by the end of this year.

HIPAA established MIP as a replacement for previous Medicare contractor audit and anti-fraud efforts. MIP's money comes directly from the Medicare Trust Fund, with aggressive annual increases through 2003 (see article, p. 8). The main work now consists of Part A cost report audits, medical review, anti-fraud investigation, and Medicare secondary payer audits (**MHFM**, 3/23, p. 8).

HIPAA provided that government competitive contractor rules should apply to MIP, and that over the long term the MIP contractors should not by right be the existing claims contractors.

HCFA has issued two proposed documents: rules to govern the ocntracting (63 *Fed. Reg.* 13590 (3/20/98)), and a 300-page Statement of Work, or SOW. The rules primarily address contracting procedures and conflicts of interest. The SOW, released April 6, addresses such issues as performance measurement and incentives, but is not detailed on the work that PSCs would perform.

Both documents are in their comment periods and must be finalized, and clearly provide for gradual implementation of HIPAA's changes including replacement of contractors. There will be no requests for proposals until later in the year.

Before the conference, HCFA recognized several possible internal contradictions in the PSC program. First, it wants to better tie PSC work to preventing improper payments from being made in the first place, yet it wants to separate MIP contractors from claims contractors.

Second, it recognizes that it still will rely on the claims contractors as the repositories and sometimes the analyzers of records; otherwise, said the agency, health "law enforcement would come to a grinding halt." And third, it wants to centralize PSCs rather than distribue them among the states, while it recognizes a need for a local investigative presence everywhere. ■

LEGISLATION AND REGULATION

Legislative/Regulatory Update

PRIVACY LEGISLATION -- Senate Labor and Human Resources Committee Chairman Jim Jeffords (R-VT) introduced a medical privacy bill (S. 1921) April 2 that could sharply crimp public and private health fraud investigations.

The proposed Health Care Personal Information Nondisclosure Act, or Health Care PIN Act, could particularly affect private fraud investigations. Private health plans, providers and professionals would have no right to obtain from another organization "personally identifiable health information" without the patient's cosent outside the initial billing situation or a legal proceeding. For instance, private insurers could not obtain such information to investigate whether legal action or a referral to law enforcement is warranted. The only exception would be if the private entity was considered a "health care oversight agency" under the bill. **William Mahon**, president of the National Health Care Anti-Fraud Association in Washington, DC, said this term is somewhat vague in the bill, but might apply to managed care organizations.

The bill could even affect law enforcement investigations. While it would allow personal health information to be disclosed in a civil lawsuit pursuant to a subpoena, it would require that the subpoena be disclosed to and challengeable by the patient. A patient might be able to prevent the disclosure unless the data was placed at issue in the case by the patient. Also, some law enforcement agencies might not be considered "oversight agencies" under the bill.

Violations of the bill's strictures would be subject to private suits, civil fines up to $100,000 per violation, and criinal fines up to $500,000 per violation. The bill would preempt all state law in the area. Jeffords's state, Vermont, has no statutes in this area.

Mahon, whose organization does not lobby, said Congress members should have a "realistic understanding of how such identifiable information is necessary" for many fraud investigations. Congress should "not inadvertently close doors [to fight fraud that] it opened up in 1996 in HIPAA," said Mahon. Medical privacy "is certainly an idea whose time has come in Congress," he noted.

Sen. Chris Dodd (D-CT) joined Jeffords in introducing the bill, while two other senators who have had privacy bills in the past, Sens. Bob Bennett (R-UT) and Patrick Leahy (D-VT), did not. Bennett and Leahy support law enforcement disclosure provisions similar to Jeffords's.

Jeffords, whose committee is considering his bill, said he hopes to pass it this year.

OIG ADVISORY OPINION/Pharmacy -- Discounts given by a generic drugmaker to wholesalers, to carry the drugmaker's version of certain drugs that have competing producers, are legal though given partly in return for marketing performed by the wholesalers, HHS/OIG chief counsel **D. McCarty "Mac" Thornton** ruled April 8. **(HHS/OIG Advisory Opinion #98-2, 4/8/98)**

Like the orthopedic equipment sales arrangement rejected by Thornton a few weeks ago **(MHFM, 4/6, p. 6)**, the discounts in this opinion vary with the amount of business between the manufacturer and a given wholesaler. But unlike the orthopedic arrangement, the drug discounts cannot be called a commission, said Thornton, because the party receiving the discounts was also the true buyer of the drugs.

Also important in his reasoning were that: (1) the portion of the discounts attributable to the marketing tasks is 25% or less; (2) the tasks are limited mainly to telemarketing and advertising, which Thornton viewed as "straightforward" sales promotions; (3) the "context" is generic drugs, more of a "commodity" than most medical products or services; (4) the manufacturer offers this arrangement to any wholesaler that accepts it; and (5) the method for calculating the discount was fully set forth in writing and fully disclosed to Medicaid as required by regulations.

Thornton said the arrangement does not fit the anti-kickback statute's safe harbor for discounts because neither party, the manufacturer or wholesaler, would be billing Medicaid.

However, he concluded, the discounts were not "prohibited remuneration" under the statute.

Thornton said at a health fraud seminar in March that requests for OIG advisory opinions had slowed down after an initial flurry when the process began last year. OIG had received less than 30 such requests since the process began, he said.

OIG ADVISORY OPINION/Hospitals and Ambulances -- A hospital/PPO may contribute an ambulance to a municipal fire department provided it offers no incentives to take patients to that hospital, Thornton ruled in an opinion posted April 14. **(HHS/OIG Advisory Opinion #98-3, 4/14/98)**

A preferred provider organization (PPO) owns a hospital that has one of three fully equipped emergency rooms in a county. The hospital is 10 miles from City X, the main population center of the county. The other two hospitals are in City X. City X's ambulances have generally been refusing to drive patients to the hospital even when patients request it because of a shortage of vehicles, and the City government states it cannot afford a new ambulance. The PPO wants to give the City an ambulance at a cost of $150,000. The PPO promises not to make further donations to the fire department for another five years.

Unlike the ambulance restocking proposal rejected by Thornton late last year, this gift is not designed to "steer" patients to the PPO's hospital. While it probably will bring more traffic to the hospital's ER, that is because it would redress an "unfair competitive disadvantage" now operating against that hospital, said Thornton: the City's inability to transport patients who want to go to that hospital.

No one would have a financial incentive to take a given patient to that hospital.

The gift would not tend toward overutilization because the City would not take people to hospitals unnecessarily simply because it has another vehicle. True emergency patients from the City will still be taken to one of the two City hospitals. The gift would expand choice and speed of service for non-emergency people who want to go the PPO's hospital.

Thornton concluded that the gift simply "would not constitute grounds for sanction under the anti-kckback statute" -- a matter of prosecutorial discretion. He emphasized that the opinion's analysis was based on the intent and incentives in this particular case.

ILLINOIS/Managed Care -- Illinois enacted last December Medicaid fraud legislation extending the reach of state prosecutors to the dealings of Medicaid managed care organizations and their providers. The new law, codified at 305 ILCS 5/8A-13, follows the model developed in 1996 by the National Association of Medicaid Fraud Control Units (see **MHFM**, 4/6, p. 7). ■

IN-DEPTH ANALYSIS

Budgets/Anti-Fraud Programs

HCFAC: Not a "Bounty" System

This completes our review of federal health enforcement funding mechanisms beyond normal agency appropriations. Earlier we described federal funding for state Medicaid Fraud Control Units (2/9, p. 8), and the activities of HCFA's Medicare Integrity Program (3/23, p. 7).

The Health Care Fraud and Abuse Control (HCFAC) Account, the HIPAA system for funding federal health enforcement efforts, is -- contrary to a widely held belief -- not a "bounty" system.

The HCFAC legislation in § 201 of HIPAA (§ 1128C of the Social Security Act) provides that winnings (primarily restitution and False Claims Act penalties) from health enforcement cases go into the Medicare Trust Fund, and that the Trust Fund pays for the HCFAC Program. But the amount of winnings has no effect on the level of HCFAC spending.

Instead, explained an HHS/OIG official familiar with the Program, Congress set the level of annual HCFAC funding. In the August 1996 statute, Congress "avoided any appearance . . . of a bounty," the official said. What the Program gets is fixed "whether we pull in a zillion dollars [in winnings] or 89 cents."

The levels Congress set were $104 million in Fiscal Year 1997 and a 15% annual increase (a much bigger increase than most federal bureaucracies get) through FY 2003, and then continued funding at the 2003 level. That means $119.6 million this fiscal year, and $137.5 million in FY 1999.

HCFAC is strictly a spending sub-account of the Trust Fund, not a collection account for winnings. HIPAA provides that winnings, whether penal amounts or restitution, go to the Trust Fund directly, not to HCFAC.

Four Separate Funding Mechanisms

The four major HHS/DOJ sub-agencies in the health fraud field -- OIG, HCFA, the FBI and the U.S. Attorney's Offices (USAOs) -- all have different HCFAC funding mechanisms. (The other three major federal agency players in health, the Defense and Veterans Affairs Departments and the Office of Personnel Management (as manager of FEHBP), get nothing from HCFAC except possibly small discretionary grants.)

The range of OIG's piece of the overall HCFAC pie is set in the statute. Last year the range was $60-70 million, and OIG actually received $70 million. (Largely offsetting that block of new funding was a sharp reduction in OIG's normal appropriations; the concept is that all of OIG's health fraud work is now paid by HCFAC.) This year the range is $80-90 million, and the actual amount is about $85 million. Next year the range is $90-100 million. The Clinton HHS budget proposed an actual allocation of $100 million, more than three-quarters of OIG's projected budget (**MHFM**, 2/9, p. 6).

OIG's precise allocation and the use of the rest of HCFAC's annual funding are decided under the

statute by HHS Secretary Donna Shalala and Attorney General Janet Reno. Assisting them on these decisions, a DOJ official said, is an Executive Level Health Care Fraud Policy Group composed of representatives of DOJ's civil and criminal divisions and the FBI, and HHS's OIG, HCFA and Office of General Counsel.

In FY 1997, HCFAC's first year, the USAOs received $8.5 million, spread rather thinly among the 94 offices. Their allocation this year almost tripled to $24.0 million. Thus, there is only about $11 million of HCFAC funds this year not going to OIG or the USAOs, down from about $25 million last year. The largest such recipient was Justice's civil division, which received $9.7 million last year.

Also last year, $1.5 million was given in miscellaneous grants largely to state MFCUs. DOJ/HHS have not yet put out a request for proposals for such grants this year, and may not at all, the OIG official indicated.

FY 99 HCFAC allocations are not set yet.

The FBI and HCFA are tied only technically to HCFAC. HIPAA appropriated FBI health fraud money from FY 97 to 2003 and thereafter, going from the Treasury's general fund "through" HCFAC to the FBI. The annual increases are rapid: 1997, $47 million; 1998, $56 million; 1999, $66 million; 2000, $76 million; 2001, $88 million; 2002, $101 million; and 2003 and thereafter, $114 million.

Similarly, HIPAA appropriated Medicare Trust Fund money to go "through" HCFAC to HCFA's Medicare Integrity Program, with jumps as follows from 1997 to the years after 2002: $440 million; $500 million; $560 million; $630 million; $680 million; $700 million; and $720 million.

The USAOs apply to the Executive Office for USAOs in Washington for new HCFAC positions and operating funds (rent, telephones, automated litigation support, etc.). **Robert Liles**, health fraud coordinator in the Executive Office, said the applications are judged by "standard cost factors for new positions" and by the strengths of justifications for new positions and for emergency funding. Once a new position (such as an AUSA, auditor or investigator) is approved and filled, it carries over into future fiscal years.

Winnings come in through many parts of the government. FCA penalties and multiple damages, which make up about 98% of penal collections, go through the USAOs or the DOJ civil division. Criminal fines are collected by the courts and tracked by the USAOs, and CMPs are collected by OIG or HCFA. Asset forfeitures are collected by U.S. Marshals.

Restitution, which in FY 97 was about eight times the penal collections, goes to HCFA for Medicare and through the Departments of Defense and Veterans Affairs for their programs.

Overall tracking of Trust Fund winnings and of HCFAC spending is coordinated by a unit under **Carol Cribbs** in DOJ's Justice Management Division.

Penal collections in the first half of FY 98 (10/1/97-3/31/98) were $52 million, running behind last year's record full-year pace of $136 million. Criminal fines, which totalled $46 million last year, came to just $500,000 so far this year. ■

Document Ordering

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