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Report to the Chairman, Permanent Subcommittee on Investigations, Committee on Governmental Affairs, United States Senate

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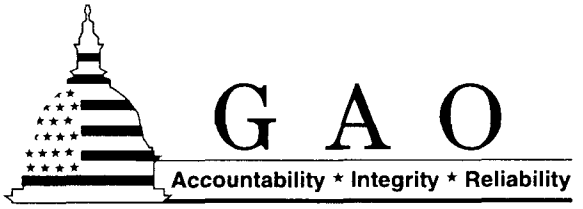
MEDICARE

Improprieties by Contractors Compromised Medicare Program Integrity



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Office of Special Investigations

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July 14, 1999

The Honorable Susan M. Collins
Chairman, Permanent Subcommittee on
Investigations
Committee on Governmental Affairs
United States Senate

Dear Madam Chairman:

This report responds to your June 4, 1998, request that we assist the Subcommittee in its ongoing review of fraud, waste, and abuse in the Medicare federal health insurance program.[1] You asked that we determine if Medicare contractors participate in any improper or questionable practices that contribute to fraud, waste, or abuse. Specifically, we agreed to (1) identify recently completed cases of criminal conduct or False Claims Act[2] violations committed by Medicare contractors, (2) describe the deceptive contractor activities set forth in those cases or alleged by investigating agents and former contractor employees, and (3) describe how these activities were carried out without detection by the Health Care Financing Administration (HCFA). In addition, in the course of our work, we assessed the impact of these activities on the Medicare program.

As you are aware, GAO conducted a related review concerning weaknesses associated with HCFA's oversight of Medicare contractors. A report of that review, entitled Medicare Contractors: Despite Its Efforts, HCFA Cannot Ensure Their Effectiveness or Integrity (GAO/HEHS-99-115), addresses these weaknesses and cites systemic problems within HCFA that allowed contractor fraud and other improprieties to occur. The report recommends both that HCFA take specific actions and that Congress consider changes in HCFA's contracting authority to improve its ability to manage contractors.

In this report, we focus primarily on three cases in which criminal and/or civil actions were brought. The three Medicare contractors—Blue Cross

[1]Medicare covers people age 65 and over and disabled individuals under age 65.

[2]The False Claims Act, 31 U.S.C. § 3729-3733, imposes civil liability on persons, including corporations, that present or cause the submission of fraudulent requests for payment (claims) to the government.

Blue Shield (BCBS) of Illinois, Blue Shield of California, and BCBS of Michigan—engaged in, or were alleged to have engaged in, activities designed to create the false appearance that they were meeting the criteria for Medicare contractors as established and evaluated by HCFA. Indeed, one factor common to the three contractors was that contractor employees at all levels participated or acquiesced in such activities to preserve the Medicare contracts and their jobs under the contracts. Details of cases involving three other Medicare contractors—BCBS of Massachusetts, Pennsylvania Blue Shield, and BCBS of Florida—which show a similar pattern of activity, are provided in appendix I. A brief summary of the actions against all six contractors is provided in appendix II.

Results in Brief

Since 1993, criminal and/or civil actions have been taken against at least six Medicare contractors resulting from their performance under Medicare contracts. The alleged contractor activities addressed in those actions occurred during the calendar years 1984 through 1997. With respect to three of the six contractors—BCBS of Illinois,[3] Blue Shield of California, and Pennsylvania Blue Shield[4]—the contractors and/or some of their employees pled guilty to various criminal charges and agreed to pay criminal fines and/or civil penalties. Investigations of the three other contractors—BCBS of Massachusetts, BCBS of Michigan, and BCBS of Florida—resulted in civil settlements only. A total of over $261 million was assessed in criminal and civil penalties against these six contractors.

Investigators from the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) and the Federal Bureau of Investigation (FBI), relators,[5] and other former contractor employees told

[3]BCBS of Illinois is also known as Health Care Service Corporation.

[4]Highmark, Inc., doing business as Xact Medicare Services, is the corporate successor to Pennsylvania Blue Shield.

[5]Under section 3730 of the False Claims Act, a private individual (known as a "qui tam plaintiff" or "relator") with independent and direct knowledge that an entity has presented, or caused the submission of, fraudulent requests for payment to the government may pursue civil false claims on behalf of the government by filing a qui tam action in the name of the U.S. government. If the government decides to join the action, it assumes primary responsibility for prosecuting the case although the qui tam relator may continue as a party to the action. The False Claims Act requires that successful relators receive compensation of 15-30 percent of the recovery from the defendant, depending on whether the government intervenes. The defendant must also reimburse the successful relator for reasonable case expenses and attorney's fees.

us that, contrary to their contractual requirements and obligations, contractors

1. improperly screened, processed, and paid claims, resulting in additional costs to the Medicare program;

2. improperly destroyed or deleted claims;

3. failed to recoup overpayments to Medicare providers within the prescribed time and to collect required interest payments;

4. falsified documentation and reports to HCFA regarding their performance; and

5. altered or hid files that involved claims that had been incorrectly processed or paid (hereinafter problem files) and altered contractor audits of Medicare providers before HCFA's reviews.

The persons to whom we spoke also told us that these deceptions and improprieties became a way of doing business and continued for sustained periods without detection because HCFA, in its review of Medicare contractors, relied on information provided by contractors without independent verification. HCFA also gave contractors advance notice of the files that it intended to review, thereby allowing contractors ample time to "correct," delete, or hide claim-related documents or redo provider audits and related workpapers prior to HCFA's review. This system also resulted in contractors deviating from their normal operating procedures during HCFA evaluations in order to deceive HCFA about their accuracy and efficiency in claims processing and customer service. As a result, criminal and other improper activities were uncovered only after whistleblowers, or relators, filed qui tam complaints under the False Claims Act.

Medicare—an approximately $200 billion, federally funded program—loses money when its contractors pay more than they should on claims and fail to properly recoup overpayments to providers. Further, in covering up their shortcomings, contractors obstruct HCFA's ability to evaluate them on their merits and to correct persistent problems.

The realization that some contractors had defrauded HCFA in order to achieve maximum evaluation scores rather than maximum performance was one of several reasons why HCFA changed the manner in which it

evaluates contractors beginning with fiscal year 1995.[6] However, according to documents filed in the BCBS of Illinois case and the Pennsylvania Blue Shield case, the criminal and other improper activity by contractors continued after HCFA had changed the manner in which it performed the evaluations.

Background

Medicare provides coverage in two parts. Medicare Part A, or hospital insurance, covers such services as those provided by inpatient hospitals, skilled nursing facilities, and hospices. Medicare Part B, or supplementary insurance, covers physician services, outpatient laboratory services, and a wide array of other health services. Most Medicare beneficiaries receive health care on a fee-for-service basis.[7] Under fee-for-service, providers are reimbursed for each covered service that they deliver to beneficiaries.

HCFA contracts with insurance companies and other entities to process fee-for-service claims. Contractors are known as "fiscal intermediaries" or "carriers," depending on the type of claims that they are responsible for processing. Section 1816 of the Social Security Act (42 U.S.C. § 1395h) authorizes HCFA to contract with "fiscal intermediaries" to process and review all Medicare Part A claims and certain types of outpatient claims under Part B.[8] In addition, section 1842 of the Social Security Act (42 U.S.C. § 1395u) authorizes HCFA to contract with "carriers" to process and review Medicare Part B claims from doctors and suppliers in a particular geographical area.

Through fiscal year 1994, HCFA evaluated contractor performance nationwide through its Contractor Performance Evaluation Program (CPEP). CPEP evaluated contractors' performance annually against a set of standards announced at the beginning of each fiscal year. The standards emphasized claims processing, service to the provider and the beneficiary, payment safeguards, administrative management, and program efficiency.

[6]For more detail about HCFA's reasons for changing its contractor evaluation process, see Medicare Contractors: Despite Its Efforts, HCFA Cannot Ensure Their Effectiveness or Integrity (GAO/HEHS-99-115), ch. 2.

[7]Alternatively, Medicare beneficiaries may opt to enroll in Medicare's managed care program by choosing a prepaid health plan for which a single monthly payment covers any needed service. This report deals primarily with the fee-for-service Medicare plan.

[8]The largest fiscal intermediary is the Blue Cross Blue Shield Association, which subcontracts with local Blue Cross plans as it did with BCBS of Michigan.

During CPEP audits, HCFA auditors would examine samples of a contractor's files from various Medicare contractor units to determine a CPEP score for functions performed by each unit.

HCFA used the numerical CPEP scores to rank the contractors, correct inadequate performance, and make determinations as to whether contracts should be renewed. In addition, under certain contracts, HCFA used CPEP scores to award incentive payments to or assess liquidated damages against contractors.[9] According to HCFA, these practices unfortunately resulted in some contractors concentrating on defrauding HCFA to achieve maximum CPEP scores rather than maximum performance. Due, in part, to such fraudulent activities, HCFA terminated CPEP, along with numerical scoring and contractor ranking, in 1994.

In fiscal year 1995, the Contractor Performance Evaluation (CPE) replaced CPEP. This process allows review of any contractor activities, including claims processing, customer service, payment safeguards, fiscal responsibility, and administrative activities. HCFA may conduct data reviews and/or process assessments on-site or at its office. In an effort to promote contractors' continuous improvement, HCFA evaluators now have greater flexibility in determining the appropriate types and levels of review for individual contractors. The HCFA Regional Office reviewer provides narrative findings to the contractor and meets with staff to spell out the areas of its operations that require corrective action.

Fiscal intermediaries and carriers have a tremendous financial responsibility. A November 1998 report issued by the HHS Inspector General (IG) addressed Fiscal Intermediary Fraud Units and noted that fiscal intermediaries were responsible for $130 billion, or 75 percent, of total Medicare payments for fee-for-service claims in 1996 alone. The same year, carriers handled the other 25 percent, or approximately $43 billion.

Criminal and Civil Actions Against Medicare Contractors

The following information addresses the criminal and civil actions taken against BCBS of Illinois and Blue Shield of California and the civil action taken against BCBS of Michigan. With respect to each of the contractors, relators had filed qui tam complaints under the False Claims Act, which

[9]Under a limited number of incentive contracts, some contractors, including BCBS of Illinois, received incentive payments for meeting identified performance levels. Some contracts also contained provisions for liquidated damages if performance fell below specified levels.

precipitated investigations by the government and, in two of the three cases, subsequent criminal charges.

BCBS of Illinois

BCBS of Illinois was investigated for activities concerning its responsibilities as a carrier under its Medicare Part B contract for the states of Illinois and Michigan[10] by the HHS-OIG, FBI, and U.S. Postal Inspection Service, in conjunction with the U.S. Attorney's Office (Southern District of Illinois, Fairview Heights, Illinois) and the Department of Justice. The investigation arose after an employee of BCBS of Illinois (the relator) filed a qui tam complaint in March 1995 alleging, among other things, that in carrying out its duties as a Medicare Part B carrier, BCBS of Illinois had knowingly made false statements and submitted false claims to HCFA. Among other things, the complaint alleged that the contractor had failed to process claims in accordance with HCFA guidelines, failed to handle beneficiary and physician telephone inquiries in a timely manner, and falsely reported its performance for CPEP. The relator filed an amended complaint in August 1997, alleging additional improprieties. In April 1998, following its investigation, the federal government intervened and took over primary responsibility with respect to a number of the allegations.

In July 1998, BCBS of Illinois entered into a settlement agreement with the federal government and the relator, in which it agreed to pay a $140-million settlement amount. In the settlement agreement, BCBS of Illinois admitted it had committed some of the allegations and denied others but did not specify the allegations being admitted or denied.

In July 1998, BCBS of Illinois pled guilty to criminal charges of conspiring to obstruct a federal audit (18 U.S.C. § 371—one count), endeavoring to obstruct a federal audit (18 U.S.C. § 1516—one count), and making false statements (18 U.S.C. § 1001—six counts) and agreed to pay a $4-million criminal fine. The relevant periods of criminal conduct were April 1984 through February 1996 on the conspiracy count, May 1993 through July 1993 on the obstruction count, and October 1994 through November 1994 on the false statement counts. In the criminal plea agreement, BCBS of

[10]BCBS of Illinois was the Medicare Part B carrier for the state of Illinois from at least 1983 through 1998. It also became the Medicare Part B carrier for the state of Michigan in 1994, retaining this responsibility through 1998.

Illinois admitted that it had received a total of $1,291,050 in incentive payments from the federal government because of its actions.

In addition to the above criminal counts against the corporation, during 1998 and early 1999, three former BCBS of Illinois managers pled guilty to criminal charges of conspiracy and obstruction of a federal audit. The activity covered by those plea agreements occurred collectively between 1987 and 1994 and was similar to the activity to which BCBS of Illinois pled guilty. One of the three managers also pled guilty to wire fraud. Criminal trials against at least five other managers are pending. They were indicted in July 1998 on charges of conspiracy, obstruction of a federal audit, mail fraud, and wire fraud for the same type of activity, which allegedly occurred between April 1984 and February 1996. Four of the five managers were also indicted on the charge of making false statements in matters within the jurisdiction of HCFA and HHS.

Blue Shield of California

The HHS-OIG investigated Blue Shield of California for activities concerning its responsibilities as a carrier under a Medicare Part B contract covering a portion of the state of California. The investigation began in October 1994 after the filing of a qui tam complaint under the False Claims Act by a former employee (the relator). The complaint, which was amended in July 1995, alleged that Blue Shield of California had knowingly submitted, or caused the submission of, false or fraudulent claims for payment to officials of the federal government. It further alleged that Blue Shield of California had knowingly used false records or statements to obtain payment of the false claims and to conceal, avoid, or decrease an obligation to pay or transmit money or property to the federal government. The complaint, as amended, also alleged that from at least 1987 until 1994, Blue Shield of California had cheated in CPEP evaluations through various improper practices, obtaining significantly higher scores than it should have. In April 1997, the federal government filed a notice of election to intervene in the pending qui tam action.

In the resulting settlement agreement filed in April 1997, Blue Shield of California agreed to pay the federal government $12 million. The settlement agreement notes that it was made in compromise of disputed claims and does not constitute an admission of wrongdoing or fault of any kind on the part of Blue Shield of California.

In April 1996, Blue Shield of California also pled guilty to criminal charges of conspiring to obstruct a federal audit (18 U.S.C. § 371—one count) and

endeavoring to obstruct a federal audit (18 U.S.C. § 1516—two counts) and was ordered to pay a $1.5-million criminal fine. The document supporting the plea agreement, entitled "Factual Basis for Pleas of Guilty," specified that from at least November 1988 through 1994, Blue Shield of California employees and supervisors in multiple units in the Part B component of the Medicare Division had obstructed HCFA's annual CPEP audits and ongoing quality assurance inspections. They had done so by altering files and documents to be reviewed by HCFA. Actions by the contractor included the selection or structuring of samples for HCFA review that were not random as requested by HCFA; the deliberate failure to report errors to HCFA as required; the discarding of documents reflecting errors; and the substitution of revised, backdated documents in place of documents containing errors.

The criminal information filed with the criminal plea agreement in this case indicates that the object of the conspiracy was to conceal instances of poor performance under the carrier contract and to deceive HCFA into giving Blue Shield of California artificially inflated CPEP scores, so that Blue Shield of California could retain its Medicare Part B carrier contract.

BCBS of Michigan

HHS-OIG and the FBI started the investigation of BCBS of Michigan after a former employee (relator) filed a qui tam complaint in June 1993.[11] The qui tam complaint alleged that BCBS of Michigan had knowingly submitted, or caused the submission of, false or fraudulent claims to the federal government for payment. It also alleged that BCBS of Michigan had knowingly used false records or statements to obtain payment of false or fraudulent claims from the federal government or to conceal, avoid, or decrease an obligation to pay or transmit money or property to the federal government. The complaint further alleged that from 1988 through 1993, BCBS of Michigan (1) routinely engaged in a crash program whereby it performed additional work on the audits of providers and altered workpapers in order to fix deficiencies and then forwarded the doctored papers to HCFA for review rather than the original workpapers as required; (2) concealed its "clean up" efforts from HCFA and the participating hospitals; (3) lied to HCFA about the status of certain of its audits of providers to steer HCFA away from those audits that were so poorly done

[11]As a fiscal intermediary, BCBS of Michigan was responsible for the administration of Part A (hospital insurance) of the federal Medicare program in the state of Michigan, including claims processing and the auditing of provider (hospital) cost reports to ensure that Medicare was not reimbursing hospitals for improper or unallowable charges.

and full of errors that they could not be fixed prior to submission to HCFA; and (4) circumvented a requirement to collect provider overpayments within 30 days by using various evasive means to make it appear that payments were collected on time when, in fact, they were not.

In January 1995, this case was settled for $27.6 million. An HHS-OIG agent told us that BCBS of Michigan had readily admitted to the improprieties during the investigation. However, in the settlement agreement, the contractor denied the allegations contained in the qui tam complaint.

Also in January 1995, a related but separate civil action, which HCFA had filed against BCBS of Michigan, was settled for $24 million. It involved Medicare Secondary Payer (MSP) issues[12] and BCBS of Michigan's use of Medicare trust fund monies to pay claims for which other insurers may have been responsible.

Deceptive Contractor Activities

Medicare contractors in our review performed, or were alleged to have performed,[13] numerous criminal or otherwise fraudulent or improper activities to deceive HCFA. In the three primary cases on which we focused, federal investigators documented many of the activities alleged by the qui tam relators. The contractors' deceptive activities, or allegations thereof, included, among other things, improper screening, processing, and payment of claims and falsification of reports and documentation.

Common Factors Regarding Contractors Reviewed

All three contractors that we reviewed in depth were accused of committing criminal and/or civil violations of law with the goal of inflating CPEP review results and creating the appearance that they were meeting or exceeding HCFA's requirements for Medicare contractors. Two of the contractors pled guilty to criminal violations regarding such acts.

[12]In the early to mid-1980s, Congress passed legislation making Medicare the secondary payer on claims involving beneficiaries who are also covered by Black Lung, Veterans Health Administration, or private employee health plans, which are now treated as primary payers. HCFA requires carriers to send MSP letters to beneficiaries for completion when a Medicare claim is first filed for their benefit. MSP letters establish whether beneficiaries are covered by other insurance plans, are used to determine the order in which Medicare will pay claims relative to other insurers, and affect the dollar amount Medicare will pay on claims.

[13]Medicare contractors denied or did not acknowledge wrongdoing with respect to all or some of the allegations made by the qui tam relators or investigators. For example, in their respective settlement agreements, BCBS of Michigan denied all allegations while BCBS of Illinois admitted to certain allegations and denied others.

According to investigators and former contractor employees, the contractors feared losing their contracts and related employee jobs if they did not meet HCFA's expectations. HCFA did not renew any of the three Medicare contracts after the improper activity was exposed.

Investigators and former contractor employees told us that manipulating samples, covering up errors, and fixing records slated for HCFA's review became a way of life for each of the contractors. These activities were viewed as the only way to get through CPEP reviews. According to investigators and relators, the contractors believed that HCFA's demands under the contracts were unreasonable, given their staffing and funding levels. Contractor management, according to relators, viewed their improprieties as a game all contractors played, "a dance we do," "a wink and a nod" at the requirements. Further, according to investigators and relators, contractors believed that it was easier to carry on improper and/or fraudulent activity than to tell HCFA that they could not meet contract requirements under existing funding and risk losing the contracts.

According to public records and statements by investigators and former contractor employees, employees at all levels of the three contractors—including vice presidents, directors, managers, supervisors, and staff-level employees—were aware of and participated in criminal and/or other improper activity. Such activities allegedly spread as employees at various levels and units taught each other how to commit such improprieties. Moreover, according to investigators and one former contractor employee, management harassed or threatened some employees into going along with improper activity, warning them that they would lose their jobs if they failed to do so.[14] "A lot of good people [were] swept up in questionable activity," according to one relator. Further, at least one investigator and all three qui tam relators indicated that they believed that criminal and/or other improper activities also spread between various contractors as employees moved from one contractor to another and as outside health care consultants were hired to help improve the contractors' CPEP scores.

[14]In his amended qui tam complaint, the relator in the Blue Shield of California case alleged that Blue Shield of California terminated his employment because he had refused the demands of his supervisor to commit violations of state and federal laws including the False Claims Act, because he had refused their demands to conceal such violations, and because his supervisors believed that he had reported Blue Shield of California's misconduct to law enforcement officials. The case was settled by agreement of the parties in 1997.

Specific Criminal and/or Other Improper Activity or Allegations Thereof

According to public records and the statements by investigating agents, qui tam relators, and other former contractor employees, the three contractors on which we focused had engaged in various types of illegal or improper activities from 1984 through 1997. Those activities are discussed below.

Improper Screening, Processing, and Payment of Claims

HCFA required contractors to properly screen and process claims to ensure that (1) claims submitted for payment were, in fact, eligible for payment under the Medicare program and (2) Medicare paid the appropriate amount on claims. Contractors' computer edits were designed to catch claims with errors or other problems. Claims that contained errors or that were incomplete were to be developed before payment to ensure that payments were correct. Failure to do so could result in additional costs to Medicare, including the contractors' use of Medicare funds to pay claims that were the responsibility of other insurers, or in over- or underpayment to claimants.

Both BCBS of Illinois and Blue Shield of California admitted in their plea agreements and related stipulation of facts/factual basis for plea to concealing errors from HCFA related to their payment of claims. Moreover, in a civil action, separate from the qui tam action, HCFA alleged that BCBS of Michigan had paid MSP claims as if Medicare were the primary payer when it should have paid the claims with Medicare as the secondary payer. This action was settled for $24 million in January 1995.

From our interviews, we gained the following information about such activities.

- According to a former contractor employee other than the relator, BCBS of Illinois sometimes failed to send out MSP letters to beneficiaries, thus using Medicare funds to pay claims that were potentially the responsibility of other insurers. During a computer-system transition in about 1989-1990, a contractor supervisor directed that approximately 5,000-6,000 claims be paid although no MSP letters had been issued. According to the investigating agents, when HCFA then requested some of these claims for CPEP review, BCBS of Illinois falsified the MSP letters and included them in the files for HCFA review.
- According to the qui tam complaint and another former contractor employee, BCBS of Illinois, in times of high claim inventory, paid incomplete or improperly filed claims of less than $50 without developing them as required. This practice was known as "dumping a

claim" and could result in improper claim payment. It had upper management approval and was frequently done. In her amended qui tam complaint, the relator alleged that this type of activity had taken place from 1984 through March 1995.

- According to an investigating agent, in an effort to receive the maximum payment for the number of claims processed, Blue Shield of California rushed claims through the processing system, shutting off computer edits designed to catch problem claims. Further, according to the qui tam relator and another former contractor employee, Blue Shield of California paid claims without proper physician signatures or backup documentation and denied other claims instead of developing them as required. Also, according to the relator, Blue Shield of California did not properly develop MSP claims to ensure that the claims were not the responsibility of another insurer and that Medicare paid the appropriate amount.

Improper Destruction or Deletion of Claims

Contractors admitted or were alleged to have improperly destroyed or deleted claims before processing them so as to appear to meet HCFA's timeliness standards for claims processing or to maximize their payment for the number of claims they processed.

In its criminal plea agreement and stipulation of facts, BCBS of Illinois admitted that, as part of a conspiracy, on or about October 23, 1993, it had shredded a box filled with Railroad Retirement Board medical claims, violating HCFA instructions requiring BCBS of Illinois to transfer the claims to the appropriate carrier. With regard to this activity, according to the qui tam complaint and statements by investigating agents and a former contractor employee other than the relator, a BCBS of Illinois manager shredded an estimated 10,000 3-month-old Medicare claims for Railroad Retirement beneficiaries, rather than forward them to the proper carrier. The claims had been mistakenly mailed to BCBS of Illinois and should have been forwarded to the appropriate carrier, according to HCFA's procedures for erroneously received claims. The manager warned the relator, who had originally found the claims, to tell no one about the shredding incident and threatened to place the blame on the relator if the incident was disclosed, warning that the relator could go to jail. According to the investigating agents, the manager, when interviewed, told them that the claims in question had been electronically submitted to the proper carrier. However, in his later plea agreement and stipulation of facts, the same manager admitted that he had shredded the claims and failed to forward them to the proper carrier.

Furthermore, according to the qui tam complaint and statements by investigating agents and a former contractor employee other than the relator, BCBS of Illinois, using special computer coding, sometimes deleted (by pulling from the normal processing line) claims that contained incomplete or incorrect information, which needed development, in order to eliminate backlogs of unprocessed claims. Once deleted, the claims were neither paid nor developed. Claimants were neither notified of the nonpayment of their claims nor informed of the items that needed development. BCBS of Illinois employees were instructed to tell inquiring claimants that the claims had never been received and should be refiled. Because claimants were not notified of the underlying problems with the original claims, they potentially resubmitted claims with the same problems a number of times. This activity, according to the amended qui tam complaint, occurred from January 1986 through January 1992.

Blue Shield of California also allegedly deleted claims. According to the qui tam relator in the Blue Shield of California case, when Blue Shield of California fell behind and was unable to process claims in accord with HCFA's timeliness standards, the contractor sometimes deleted claims and then reentered them with new dates and control numbers. In doing this, the contractor gained additional time to process the claims while it appeared to meet HCFA's timeliness criteria. This type of activity allegedly occurred from 1987 through 1994, according to the qui tam complaint.

In addition, according to an investigating agent, a Blue Shield of California manager admitted that 40,000 claims had been deleted without processing. These claims, however, were never reentered. As did BCBS of Illinois, Blue Shield of California told inquiring claimants that their claims had never been received.

Failure to Collect Medicare Overpayments and Interest as Required

HCFA required that contractors recoup overpayments to providers within 30 days of the date an overpayment was determined. If overpayments were not secured within 30 days, contractors were required to assess interest on the overpayment amount and to withhold the total amount due from future

weekly payments[15] to the providers. However, at least one contractor allegedly failed to recoup overpayments and interest as prescribed.

The qui tam complaint filed in the BCBS of Michigan case alleged that from 1988 through 1993, BCBS of Michigan had circumvented a requirement to collect provider overpayments within 30 days of the overpayment determination date. The contractor allegedly used various evasive means to make it appear that payments were collected on time when, in fact, they were not. In its January 1995 civil settlement agreement, BCBS of Michigan denied all allegations, including this one, but settled the case for $27.6 million.

When interviewed, the relator explained to us that BCBS of Michigan had not always been timely in monitoring, discovering, and collecting overpayments and interest. In order to make it appear that it had collected overpayments on time, the relator told us that BCBS of Michigan had set up a special suspense account and withheld a percentage of future weekly payments to the provider. When the account holdings were sufficient to cover the entire overpayment due, BCBS of Michigan indicated to HCFA that it had taken a second look at the provider, discovered an overpayment, and immediately assessed the provider an overpayment. The overpayment was then collected (from the suspense account) within a few days. Alternatively, it divided large overpayments into small segments, then made demand for overpayment one segment at a time, collecting each segment from the suspense account within a day or two of each demand.

The relator further stated that by handling overpayments in this way, BCBS of Michigan (1) made it appear that it had collected all overpayments within 30 days of the date of determination of overpayment and (2) denied the Medicare program the interest due on all overpayments not collected within 30 days of the overpayment determination date.

Falsified Reports Regarding Contractor Performance

HCFA's CPEP and CPE evaluations of contractor performance included, among other aspects, reviews of claims processing and payment

[15]Some Part A providers receive weekly payments from HCFA under the Periodic Interim Payment program, based on their prior-year cost reports and current-year quarterly reports. Fiscal intermediaries are required to adjust weekly payments, if necessary, each time the provider files a quarterly report. The goal is for weekly payments to total at least 95 percent of the total actual provider costs for the year. At the end of the year, the fiscal intermediary must collect any overpayment from, or pay any underpayment to, a provider, as determined by the year-end cost report, within 30 days of the date of determination of an overpayment or underpayment, per HCFA criteria.

safeguards. In support of these performance evaluations, Medicare contractors were required to file periodic reports with HCFA. Both BCBS of Illinois and Blue Shield of California admitted in their plea agreements with the government that they had falsified reports to make their performance appear acceptable to HCFA.

In its criminal plea agreement and stipulation of facts, BCBS of Illinois admitted that, as part of its conspiracy to obstruct HCFA auditors in the performance of their official duties, it had

- submitted to HCFA false reports relative to its performance under its Medicare Part B contract in various BCBS of Illinois units, resulting in false high scores and the false appearance of superior performance from April 1984 through February 1996;
- directed the falsification of monthly Post Payment Quality Assurance (PPQA)[16] reports and submitted them electronically to HCFA from 1990 through September 1995, including the submission of reports to HCFA that indicated claims had been processed error-free when, in fact, they were not error-free;
- from June 1989 through April 1990, electronically transmitted false data to HCFA concerning MSP errors with the effect of BCBS of Illinois' receiving CPEP scores on MSP to which it was not entitled; and
- admitted that six of its managers, all acting within the scope of their employment, signed a document certifying to BCBS of Illinois that no false information, manipulation of Medicare Part B data, or falsification of CPEP Medicare Part B scoring had occurred during fiscal year 1994 (Oct. 1, 1993, through Sept. 30, 1994), when, in truth, such certifications were materially false, fictitious, and fraudulent statements.

Similarly, in its criminal plea agreement and factual basis for plea, Blue Shield of California admitted that from November 1988 through 1994, its employees and supervisors in multiple units had conspired to obstruct HCFA's annual CPEP audits and ongoing quality assurance inspections by deliberately failing to report errors to HCFA.

[16]The Post Payment Quality Assurance Unit at BCBS of Illinois was responsible for checking the accuracy of those claims that had been paid. To do so, every week it (1) reviewed a sample of claims that had already been paid and (2) forwarded to HCFA a computerized record of all errors found. HCFA would later request and review the physical files for a smaller subsample of the same claims, checking the contractor's accuracy in finding its own errors.

From our interviews, we gained additional information regarding the falsification of reports that BCBS of Illinois and Blue Shield of California had submitted to HCFA. According to a former contractor employee other than the relator and the relator's attorney, BCBS of Illinois' upper management altered timeliness reports submitted to HCFA regarding the claims-processing function. BCBS of Illinois also falsified monthly telephone reports concerning the number and percentage of customer telephone calls answered within 120 seconds, as required by HCFA, according to investigating agents and the qui tam complaint. Individuals we interviewed told us that HCFA evaluated contractor response time to incoming customer telephone calls, which generally were considered "answered late" if they were not answered within 120 seconds. When BCBS of Illinois monitors showed that it was exceeding the 120-second time limit, supervisors, including the qui tam relator, were instructed to shut off some or all of its 1-800-telephone lines. This prevented (1) the calls from showing up as "answered late" on computer reports, data from which were forwarded to HCFA, and (2) customer calls from getting through.

With respect to Blue Shield of California, according to an investigating agent, in one instance during November 1994, a contractor supervisor instructed an employee to "drop," or not report to HCFA, what HCFA would have considered to be a $465,000 error. According to the investigator, the contractor's Vice President of Medicare Operations, as well as directors and managers, concurred in the dropping of problem claims. The investigator also told us that in at least one instance in 1992, the contractor, in effect, reported to HCFA that it had processed 10.4 percent of its July 1992 claim correspondence late, rather than the actual 24 percent that was late. After HCFA discovered the discrepancy, the contractor doctored a letter from a subcontractor to falsely reflect that the subcontractor, and not Blue Shield of California, was responsible for the discrepancy.

Improperly Amended or Hidden Claim and Audit Files

To circumvent HCFA's annual and periodic reviews of the contractors' actual performance, according to admissions and allegations, contractors, among other actions, improperly altered problem claim and audit files, hid problem files, or otherwise did not make problem files available to HCFA. Contractors allegedly formed special teams to improperly "fix" problem files prior to HCFA's review.

In its criminal plea agreement and stipulation of facts, BCBS of Illinois admitted that, as part of its conspiracy to obstruct HCFA auditors in the performance of their official duties, it had

- submitted to HCFA false work-processing samples relative to its performance under its Medicare Part B contract, resulting in false high scores and the false appearance of superior performance from April 1984 through February 1996;
- submitted, during May 1993, for HCFA's review 60 cases of telephone and written reviews, including 17 cases in which documents from a communications unit had been improperly removed, altered, or created prior to CPEP to conceal errors;
- accepted HCFA's audit report in July 1993, which included the audit of that communications unit, without advising HCFA that BCBS of Illinois had tampered with and altered the sample case files upon which the auditor's report was based; and
- altered PPQA claim files containing errors, which were to be reviewed by HCFA, by improperly changing copies of claim-related documents or improperly adding documents to the file to support payments and to eliminate the appearance of error. (In the amended qui tam complaint, the relator alleged that this type of activity had occurred from 1984 through 1995.)

Blue Shield of California admitted to similar actions in its plea agreement. From November 1988 through 1994 to conceal evidence of error, Blue Shield of California admitted that employees and supervisors in multiple units had periodically manipulated the selection of samples for HCFA review[17] and improperly altered the files and documents to be reviewed by HCFA.

The qui tam complaint filed in the BCBS of Michigan case alleged that from 1988 through 1993, BCBS of Michigan had routinely engaged in a crash program to "fix," or redo, audits of providers and related workpapers and forwarded the doctored papers to HCFA for review rather than collecting and forwarding the original workpapers as required. The complaint also alleged that the contractor had concealed its "clean up" efforts from HCFA and the participating hospitals and lied to HCFA about the status of certain audits in an attempt to steer HCFA away from those audits that were so poorly done and full of errors that they could not be fixed prior to submission to HCFA. In its January 1995 civil settlement agreement, BCBS of Michigan denied the allegations but settled the case for $27.6 million.

[17]According to the Criminal Information, Blue Shield of California manipulated the application of skip factors to eliminate files with significant errors and to select files with fewer errors for HCFA's sample.

Specific examples of the activities set forth in the plea agreements were provided to us in the interviews we conducted. They include the following:

- According to one former contractor employee other than the relator, after discovering 17 errors in a batch of 50 or 60 claim review cases during 1993, a BCBS of Illinois supervisor asked the employee to find a way to fix the errors. One such claim involved payment for three cataract surgeries on one individual. Although required by HCFA, the file did not contain an explanation regarding the third surgery. To fix the problem, the employee fabricated notes indicating that the contractor had contacted the claimant and determined that two surgeries had been done on one eye on different days as a result of one of the surgeries being unsuccessful. Had BCBS of Illinois not fixed the errors, it would have failed CPEP for this particular function.
- For the weekly quality assurance reviews, Blue Shield of California improperly fixed claims that had been processed incorrectly and were to be reviewed by HCFA, according to statements by a former contractor employee other than the relator. It did so, for example, by (1) stamping "signature on file" on claims that had been paid without a doctor's signature; (2) detaching documents, such as another insurance company's Explanation of Benefits, from improperly denied MSP claims to give the appearance that the denials were correct; and (3) altering procedure codes to make it appear that claims had been paid properly when they had not.
- From sample claims that HCFA had requested for review, according to the relator in the Blue Shield of California case, employees of that contractor deleted references to motor vehicle accidents for which Medicare had paid medical claims that may not have been its responsibility.

The contractors used various means to accomplish their objective. According to investigating agents and former BCBS of Illinois employees, including the qui tam relator, after HCFA had notified BCBS of Illinois in advance of the records it would review during the annual CPEP, the contractor manipulated the claims that HCFA was to review before HCFA arrived. To do so, the contractor set up a "war room" where employees improperly altered problem areas in the sample claim files to be reviewed. Their modifications included, among other things, (1) fabricating evidence by adding, creating, or altering existing documents to support payments and (2) removing and hiding files that could not be conveniently amended.

Blue Shield of California followed a similar process. It created a special team, generally a small circle of managers, to improperly correct problems in the sample claims that HCFA had requested for review, according to the investigating agent and the qui tam relator.

The qui tam relator in the BCBS of Michigan case explained to us that this contractor had hired outside health care consultants to work with a contractor "CPEP team" of auditors to prereview the records of its audits of providers (hospitals) that were slated for CPEP review. Based on their review, the consultants assigned an initial CPEP score to the records, which generally fell in the 30- to 50-percent range, according to the relator. Because HCFA required a CPEP percentage score ranging in the upper 90s, the team changed the audit records to correct the areas needing improvement. Their actions included, among other things, redoing original workpapers, improperly altering audit records, doing audit work not previously done as required, and obtaining new information from providers that should have been collected in the original audit. In some cases, BCBS of Michigan's CPEP team determined that an audit could not be adequately fixed in time for CPEP. In those cases, the contractor steered HCFA away from the problem audit by lying about its status.

Reasons Why HCFA Did Not Detect Fraudulent and Improper Activities

The investigations by the HHS-OIG, FBI, and U.S. Postal Inspection Service (in conjunction with the U.S. Attorney's Office and the Department of Justice) of each of the contractors we reviewed in depth began with the filing of a qui tam action by a current or former employee of the contractor. Prior to the qui tam actions being filed, HCFA had not detected the contractors' fraudulent and improper activities.

According to the HHS-OIG agent who investigated Blue Shield of California, HCFA received an anonymous complaint 2 years prior to the qui tam complaint, which alleged that the contractor had given false documents to HCFA to pass its annual CPEP review. According to a HCFA regional employee, HCFA reviewed the contractor at that time. The contractor stated that a computer system problem had resulted in incorrect workload reports and presented a document, purportedly from the computer system company, indicating that the problem was a computer error. Much later, it was determined that Blue Shield of California had fabricated the document.

Interviewees, including the federal investigators, provided us the following reasons for HCFA's failure to detect contractor improprieties:

- HCFA notified contractors in advance concerning (1) the dates on which it would conduct CPEP reviews and (2) the specific or probable records that would be reviewed. This gave contractors the time and opportunity to manipulate samples and adjust or hide problems.
- HCFA had contractors pull the records to be reviewed and relied on the documents provided by contractors, which consisted largely of copies, not originals. Document copies could be, and were, easily altered and recopied without detection. HCFA did not examine the original documents or sources, such as microfilm/microfiche or online or stored computer data. HCFA relied on what it was given without verification. In the case of BCBS of Michigan, HCFA had the contractor send the documents to it rather than conduct an on-site review. The relator in that case noted that HCFA would have detected problems if it had shown up on-site unannounced and selected random files for review.
- In some cases, HCFA representatives form relationships that are too close with contractors, losing their objectivity and ability to conduct meaningful reviews. This is especially true when a HCFA representative has a long or exclusive relationship with a contractor. One interviewee noted that if the contractor looks bad, the HCFA representative who performs the monitoring also looks bad.
- HCFA places too much trust in contractors, according to some investigators and former contractor employees. One investigator noted that with the change from CPEP to CPE, HCFA now places an even greater reliance on the integrity of contractors. For example, according to the investigator, HCFA now relies more fully on contractors' quality assurance units to review the accuracy of Medicare claims paid by the contractors and does not routinely review a subsample of the claims reviewed by each contractor's quality assurance unit.
- To circumvent HCFA's reviews of the contractors' actual performance and in anticipation of HCFA's review of specific processes, contractors allegedly deviated from normal procedures in an effort to deceive HCFA about their accuracy and efficiency in claims processing and customer service. For example, a former BCBS of Illinois employee other than the relator told us that in order to circumvent HCFA's periodic unannounced "test" telephone calls, which were designed to check the contractor's response time, he tracked HCFA's calls and established HCFA's pattern of calling. In response to that pattern, the unit manager put extra employees on the telephone lines during the anticipated times of the HCFA call until the call was received. In addition, according to the qui tam relator and another former contractor employee, in anticipation of CPEP, BCBS of Illinois reassigned its two most experienced

employees to conduct the claim reviews[18] that occurred on the 1-2 days preselected by HCFA for review. Contractor managers instructed these employees to slow down the review process and take their time in order to ensure that the reviews were done with 100-percent accuracy and included proper documentation.

Impact on the Medicare Program

Improprieties by Medicare contractors contribute to fraud, waste, and abuse in the approximately $200-billion-a-year Medicare program by impacting both the Medicare trust fund and customer service in the following ways:

- When contractors improperly turn off edits and fail to properly develop, process, or audit claims, several things occur: (1) Medicare pays more or less than it should on claims; (2) beneficiaries, who are obligated to pay a 20-percent co-payment on assigned claims,[19] lose if they pay 20 percent of an excessively computed amount; and (3) providers and beneficiaries are forced to resubmit claims that were improperly destroyed, deleted, or denied, causing delays in payment and unnecessary duplication of effort. When claims are denied or deleted without the claimants being notified of any underlying problems with the claims, the claimants may file replacement claims containing the same mistakes.
- When contractors fail to recoup overpayments to providers within the HCFA-mandated time period, then cover up their failure to do so, Medicare suffers not only from the untimely repayment of such overpayments but also from the lost interest that should have been assessed on overdue overpayments.
- Contractors that cover up their shortcomings deny HCFA the opportunity to evaluate them on their true merits and to correct recurring problems.

[18]Contractors conduct claim reviews when they receive requests for reconsideration of claims decisions from beneficiaries or providers contending that they were paid an incorrect amount. All reviews entail follow-up to determine the accuracy of payments made on questioned claims. CPEP reviews evaluated how well the contractor had conducted claim reviews.

[19]If a claim is assigned—meaning the provider has agreed to accept direct payment from Medicare based on the Medicare-allowable amount—the provider submits the claim to HCFA's Medicare contractor. The contractor determines the allowable amount and pays the provider 80 percent of that amount. Even if the claim amount is greater than the allowable amount, the provider must charge the beneficiary the remaining 20 percent of the allowable amount and no more.

Scope and Methodology

We conducted our investigation from September 1998 to April 1999. We interviewed HHS-OIG special agents, special agents of the FBI, and an FBI financial analyst who were involved in the investigations of BCBS of Illinois, Blue Shield of California, and BCBS of Michigan. We also interviewed the pertinent qui tam relators, one of the relator's attorneys, and three additional former employees of the Medicare contractors. We reviewed relevant case documents where available, including case reports and backup documentation. In addition, we reviewed public record documents including criminal indictments, criminal informations, stipulations of fact, a factual basis for plea, criminal plea agreements, qui tam complaints, and civil settlement agreements. We reviewed available records regarding the three other Medicare contractors—BCBS of Massachusetts, Pennsylvania Blue Shield, and BCBS of Florida—and incorporated that material into appendix II. Finally, we reviewed internal and external documents relating to the history and nature of the Medicare program's administration.

We will send copies to interested congressionalcommittees and will make copies available to others on request. If you have any questions concerning this report, please contact one of the individuals listed in appendix III. Key contributors to this case are also listed in appendix III.

Sincerely yours,

Robert H. Hast
Acting Assistant Comptroller General
for Special Investigations

Contents

Abbreviations

BCBS	Blue Cross Blue Shield
CPE	Contractor Performance Evaluation
CPEP	Contractor Performance Evaluation Program
FBI	Federal Bureau of Investigation
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	Health Maintenance Organization
IG	Inspector General
MSP	Medicare Secondary Payer
OIG	Office of Inspector General
OSI	Office of Special Investigations
PPQA	Post Payment Quality Assurance

Overview of Cases Involving Other Medicare Contractors

Other contractors—BCBS of Massachusetts, Pennsylvania Blue Shield, and BCBS of Florida—reached civil settlements regarding allegations of some of the same improprieties discussed previously. In addition, three contractor employees have pled guilty to criminal charges in the Pennsylvania Blue Shield case, which is ongoing. Their activities related to the following alleged improprieties.

Alleged Improper Activities During Contract Performance

Alleged Improper Screening, Processing, and Paying of Medicare Claims

Qui tam relators in their complaints alleged that two contractors—Pennsylvania Blue Shield and BCBS of Florida—had failed to properly screen, process, and pay claims. This allegedly resulted in additional costs to the Medicare program, including the contractors' use of Medicare funds to pay claims that were the responsibility of other insurers.

In an August 1998 civil settlement agreement, the federal government contended that from 1988 through 1996, Pennsylvania Blue Shield had (1) failed to implement Medicare requirements for screening end-stage renal disease laboratory claims; (2) inappropriately used manual computer overrides, or force codes, following the adjustment of claims to bypass electronic audits or edits; and (3) failed to properly process MSP claims. The case was settled for $38.5 million. In the settlement agreement, Pennsylvania Blue Shield made no statement as to its agreement with, or denial of, the allegations.

Accusations of similar actions by BCBS of Florida were settled civilly in August 1993 for $10 million. BCBS of Florida, during a period of backlogged claims, allegedly (1) forced Medicare claims through the system to override audits and edits intended to prevent the payment of ineligible, unallowable, or duplicate claims and (2) created false and fictitious prescriptions for certain claims for durable medical equipment. The contractor was also accused of turning off system audits and edits, including some mandated by HCFA, without HCFA's knowledge or approval. In the settlement agreement, BCBS of Florida denied the allegations.

Alleged Improper Denial or Deletion of Claims

BCBS of Florida was also accused of denying or deleting unprocessed Medicare claims from the processing system, regardless of whether such claims satisfied Medicare coverage rules, when it experienced a backlog of claims. This allegation was also addressed in the $10-million civil settlement in which BCBS of Florida denied the allegations.

Alleged Failure to Collect Medicare Overpayments in Timely Fashion

Pennsylvania Blue Shield allegedly failed to recover overpayments resulting from computer system errors. Its August 1998 civil settlement of the case for $38.5 million also covered these actions. In that civil settlement agreement, Pennsylvania Blue Shield made no statement as to its agreement with, or denial of, the allegation.

Allegations That Contractors Prevented Adequate HCFA Evaluation of Their Performance

BCBS of Massachusetts and Pennsylvania Blue Shield allegedly falsified annual and periodic reports and documentation to HCFA regarding their performance.

In 1994, BCBS of Massachusetts reached a $2.75-million civil settlement regarding accusations that it had committed CPEP fraud, which included inflating the number of claims the contractor had processed, under its Medicare Part B contract. In its settlement agreement, BCBS of Massachusetts denied the allegations except as otherwise expressly set forth in its Internal Review reports (not available). As part of its settlement agreement, BCBS of Massachusetts agreed to implement a Medicare Fraud and Abuse Program Improvement Plan, designed to increase resources devoted to the elimination of fraud and abuse by providers of medical services. The contractor retained its Part A intermediary and Part B carrier contracts until July 1997, when HCFA did not renew them.

In 1996, BCBS of Massachusetts also attained a separate Health Maintenance Organization (HMO) contract from HCFA. Less than 2 months later, however, HCFA suspended the HMO contract after it was discovered that the contractor had falsified statements related to its application for the HMO contract. In 1997, BCBS of Massachusetts reached another civil settlement for $700,000 regarding the HMO accusations. In that settlement agreement, BCBS of Massachusetts contended that the acts in question were the unauthorized acts of a single employee, undertaken without the knowledge or approval of BCBS of Massachusetts' management. The contractor's intermediary and carrier contracts were not renewed in 1997.

Pennsylvania Blue Shield allegedly committed CPEP fraud by obstructing government audits of its performance as a contractor. This action was covered under its August 1998 civil settlement for $38.5 million. Also in 1998, three Pennsylvania Blue Shield managers pled guilty to criminal charges of conspiracy, making false statements, and/or aiding and abetting in making false statements or causing false statements to be made in connection with Medicare. The related criminal informations state that at least two of the managers had conspired to (1) knowingly make materially false statements to HCFA regarding Pennsylvania Blue Shield's failure to comply with Medicare program rules, regulations, policies, and procedures; (2) knowingly cause false, fictitious, and fraudulent information to be submitted to HCFA agency reviews of Pennsylvania Blue Shield's operations; (3) conceal material facts from HCFA officials relating to Pennsylvania Blue Shield's failure to comply with Medicare program rules, regulations, practices, and procedures; and (4) make false statements to HCFA in connection with CPEP as part of a scheme to defraud HCFA and to distort the audit results in a fashion that favored Pennsylvania Blue Shield. One way in which Pennsylvania Blue Shield falsified data was to falsely represent to HCFA personnel that they were being provided statistically valid random case samples for review. In fact, the case samples were not random, and Pennsylvania Blue Shield employees had screened and manipulated them to ensure a high degree of accuracy prior to submitting them to HCFA for examination.

Summary of Criminal and Civil Actions Against Six Medicare Contractors

Contractor	Charge	Adjudication
Pennsylvania Blue Shield (Highmark, Inc.)	Medicare Secondary Payer and CPEP fraud issues.	Civil settlement of $38.5 million on 08/14/98. Criminal conviction of three employees during 1998. Investigation ongoing.
BCBS of Illinois (Health Care Service Corporation)	Altered documents to increase evaluation scores. Bypassed computer edits. Destroyed claims. Used Medicare Trust Fund to pay private claims.	Civil settlement of $140 million on 07/16/98. Criminal conviction of corporation 07/16/98 with a $4-million fine. Criminal conviction of three employees during 1998 and early 1999. Indictment of five other employees during July 1998 with criminal trials pending.
BCBS of Massachusetts	Falsified statements on HMO applications.	Civil settlement of $700,000 on 09/18/97.
Blue Shield of California	Falsified documents. Hid ongoing processing errors. Failed to process claims timely. Destroyed claims.	Criminal conviction of corporation on 04/26/96 with a $1.5-million fine. Civil settlement of $12 million on 04/30/97.
BCBS of Michigan	Used Medicare Trust Fund to pay private claims. Medicare Secondary Payer issues.	Civil settlement of $24 million on 01/10/95.
BCBS of Michigan	Falsified documents to support audits.	Civil settlement of $27.6 million on 01/10/95.
BCBS of Massachusetts	CPEP fraud. Inflated number of claims processed.	Civil settlement of $2.75 million on 09/28/94.
BCBS of Florida	Created physician orders. Bypassed computer edits.	Civil settlement of $10 million on 08/04/93.

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