U.S. Department of Justice

Associate Deputy Attorney General *Washington, D.C. 20530*

Fax Transmission Cover Sheet

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Date: **11/30/99**

Number of Pages (including Cover Sheet): **3**

Message:

DeVora – attached is an article from earlier this year in which HCFA attributed a decline in spending specifically to stepped-up enforcement efforts (to the tune of a couple of hundred million dollars). Perhaps Chris could ask HCFA's Chief Actuary to take a closer look and see if there are other areas where decreased spending can be tied to enforcement efforts. We wouldn't need many examples (4 or 5) to form the basis of a short report.

BNA's

HEALTH CARE FRAUD REPORT

BNA Employee-Owned Since 1947

VOL. 3, NO. 2 PAGES 61-96 JANUARY 27, 1999

HIGHLIGHTS

U.S. Supreme Court Approves Use of RICO in Fraud Claim Against Humana
In a decision that opens the door to the use of powerful federal remedies in health insurance fraud claims, the U.S. Supreme Court unanimously rules that a class of 84,000 Nevada plaintiffs who say they overpaid millions in medical copayments in the late 1980s can sue managed care giant Humana Inc. under the federal Racketeer Influenced and Corrupt Organizations Act. **Page 83**

Federal Efforts Said Responsible for Drop in Upcoding at Hospitals
Federal anti-fraud efforts in part have caused hospitals to code patient diagnoses less aggressively, resulting in a first-time drop in the complexity of cases between 1997 and 1998 for hospitals participating in Medicare's prospective payment system, according to a memorandum issued by the Health Care Financing Administration's Office of the Chief Actuary. **Page 68**

HCFA's Failure to Combat Fraud Puts Medicare on GAO's 'High-Risk' List
Despite Congress having enacted legislation in recent years to bolster HCFA's capability to oversee Medicare, the agency has been slow to develop initiatives to curb fraud, waste, abuse, and mismanagement, according to a new General Accounting Office report. **Page 68**

Pennsylvania HMO Reaps $63 Million From Inappropriate Costs, IG Reports
In another in a series of reports, the Department of Health and Human Services Office of Inspector General finds Medicare overpaid a managed care organization about $63 million in 1997 due to the submission of administrative cost data not allowed for Medicare fee-for-service providers. **Page 70**

Blue Cross of Massachusetts to Pay $4.75 Million for Improprer Claims
Blue Cross and Blue Shield of Massachusetts agrees to pay the federal government $4.75 million to reimburse the Medicare system for claims for which the company, and not Medicare, should have been the primary payer, the Department of Justice announces. **Page 70**

Bipartisan Group Calls on White House, Congress for More HCFA Funding
A bipartisan group of 14 health policy experts—including three former agency administrators—claim HCFA has been crippled by an unwillingness on the part of Congress and the White House to provide funding and the flexibility needed to tackle its growing responsibilities. **Page 73**

Patients Need Not Prove Improper Hospital Motive to Prove 'Dumping'
Patients who suspect they were wrongly refused emergency room treatment or "dumped" at another hospital's door do not have to prove that a hospital acted with an "improper motive" to establish a breach of the federal patient dumping law, the U.S. Supreme Court rules. **Page 84**

ALSO IN THE NEWS

PATIENT DUMPING: Responding to hospitals' concerns, the HHS IG agrees to extend by 30 days the comment period on upcoming guidance aimed at preventing hospitals from "dumping" managed care patients. **Page 71**

MANAGED CARE: The New York State Insurance Department fines 12 health insurers and managed care organizations a total of $72,200 for violating the state's 1997 prompt payment law. **Page 77**

LABOR DEPARTMENT: The Department of Labor's proposed rule to speed the handling of group health plans' claims and appeals generates so much protest from the business community and insurance industry that it may be about to face congressional scrutiny. **Page 75**

HOSPICE: The HHS IG announces it will seek industry feedback on guidance it is developing to help hospices root out fraud and stay in compliance with state and federal laws and regulations. **Page 74**

MANAGED CARE: A contract between the Connecticut Department of Social Services and a managed care organization serving 34,000 Medicaid recipients will be allowed to lapse on Jan. 31 after a state investigation turns up serious concerns regarding the provision of patient care. **Page 78**

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Federal News

Medicare

Federal Efforts Said Responsible For Drop in Upcoding at Hospitals

Federal anti-fraud efforts in part have caused hospitals to code patient diagnoses less aggressively, resulting in a first-time drop in the complexity of cases between 1997 and 1998 for hospitals participating in Medicare's prospective payment system, according to a memorandum issued by the Health Care Financing Administration's Office of the Chief Actuary.

PPS hospital case mix fell 0.74 percent through October 1998, meaning the cost of an average case fell by that amount. When data for the remainder of the year is included, the case mix should fall 0.5 percent, Gregory Savord, special assistant to HCFA Chief Actuary Richard S. Foster, said in the Nov. 19, 1998, memo, obtained by BNA Jan. 11.

If the index does fall 0.5 percent, it will save Medicare about $200 million in reimbursement not paid to hospitals, according to an industry source.

An official from the American Hospital Association could not be reached for comment late Jan. 11, but industry sources said other factors could have caused the case-mix index to fall, including an education effort among providers to better understand the payment system. Hospitals also are downcoding to appear less expensive to health maintenance organizations in an increasingly competitive health care market.

HCFA has tracked the case-mix index yearly since the beginning of PPS in 1984 and 1998 will be the first year the index has fallen, according to the memo. While overall the case-mix index has fallen, the rate for some individual diagnosis-related groups (DRGs) has risen, while it fell for others, the memo said.

More Resources Used. Case mix is the mix of patients treated within a particular hospital setting and is used as the basis for Medicare's PPS. The system uses diagnosis-related groups as the basis of payment to hospitals and, the more severe a case-mix index, the more reimbursement a hospital receives from Medicare because it implies more resources were used to treat sicker patients.

Under PPS, hospitals are paid a rate in advance for treating Medicare patients and they are paid these rates regardless of the costs they actually incur. Prospective per-case payment rates are set at a level intended to cover operating costs in an efficient hospital for treating a typical inpatient in a given DRG.

The federal government has alleged that hospitals have engaged in upcoding to increase their Medicare revenues, but hospitals have said upcoding is due to mistakes made when filing claims in what they charge is an often unclear and complicated system.

While determining exactly why the case-mix index has fallen in 1998 is difficult, Savord said the drop "is likely attributable to certain efforts to combat fraud and abuse," including investigations of Columbia/HCA Healthcare Corp. and the Department of Health and Human Services Office of Inspector General's examination of alleged upcoding by hospitals in pneumonia cases.

"The Department of Justice investigation of the Hospital Corporation of America, subsequent indictments, and the possibility of triple damages may have prompted some hospitals to code diagnoses less aggressively—resulting in fewer complex cases," the memo stated.

Under the False Claims Act, health care providers can be fined treble damages plus up to $10,000 for each false claim filed with Medicare.

"Similarly, the inspector general's investigation of pneumonia cases may have caused the significant shift of admissions from the more expensive respiratory infections DRGs to the simple pneumonia DRGs," Savord wrote.

Two Pennsylvania hospitals and one Illinois hospital agreed to pay a total of about $5 million to settle charges they overbilled Medicare by miscoding claims submitted to patients treated for pneumonia. Only one other hospital to date has settled as a result of a national investigation launched by the DOJ and the IG.

The case-mix index for the coding of pneumonia cases fell 0.23 percent in 1998, according to the AHA memo.

BY STEVE TESKE

Medicare

HCFA's Failure to Combat Fraud Puts Medicare on GAO's 'High-Risk' List Again

Despite Congress having enacted legislation in recent years to bolster the Health Care Financing Administration's capability to oversee Medicare, HCFA has been slow to develop initiatives to curb fraud, waste, abuse, and mismanagement, according to a report released Jan. 25.

The nearly 200-page General Accounting Office report (*High-Risk Series: An Update*, GAO/HR-99-1) highlights federal programs GAO considers to be at "high risk" or susceptible to waste, fraud, abuse, and mismanagement. GAO releases these reports every two years at the start of each new Congress.

Medicare has had the dubious distinction of being on GAO's high-risk list since it first began issuing the reports nine years ago, according to Sen. Susan M. Collins (R-Maine), chairwoman of the Senate Governmental Affairs Permanent Subcommittee on Investigations.

"Although we've made some progress recently, it is unacceptable to have such an important program as Medicare on the high-risk list for nine years," Collins said in a prepared statement.

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Fax Transmission Cover Sheet

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Date: **11/16/99**

Number of Pages (including Cover Sheet): **2**

Message: **Per the attached.**

Note: The information contained in this facsimile should be considered confidential.

U.S. Department of Justice

Office of the Deputy Attorney General

Associate Deputy Attorney General *Washington, D.C. 20530*

November 16, 1999

To: Chris Jennings
Deputy Assistant to the President

From: John T. Bentivoglio

Subj: Decline in Medicare spending – role of health care fraud enforcement activities

As you know, recent statistics showed that annual Medicare spending – for the first time in the program's history – decreased in fiscal 1999. Although press reports acknowledged that a number of factors contributed to the decline, experts in and out of government agree that the Administration's aggressive health care fraud enforcement efforts have played a major role.

I recommend that DOJ and HHS work together on a short report that would attempt to document the contribution of fraud enforcement to this decline. Some time ago, HCFA's actuarial office concluded that there were sharp decreases in upcoding of pneumonia – saving several hundred million dollars per year, as I recall. Significantly, there was no medical reason for the decline; rather, it can be attributed to the government's focus on pneumonia upcoding fraud. We would be happy to contribute information about enforcement actions (indictments, convictions, settlements) to the report.

The results of this report, which would not have to be elaborate (no more than 5-10 pages), could be released at a White House event, weekly radio address, or the like. In addition, the President could call upon Congress to continue the work we've done in this area by passing the legislation we proposed in the Crime Bill (and I'm sure HHS has some anti-fraud legislative proposals that they would like to push).

Our health care fraud enforcement efforts have been a huge success. We've saved billions – perhaps tens of billions – of dollars. And the President and Administration should take credit for this accomplishment – while also pushing for even greater progress.

DOJ would be happy to contribute to this project in terms of statistics, anecdotes, etc.