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From: Craig Palosky

Subject: IG REPORT

COMMENTS:

#1: HCFA'S RESPONSE TO IG REPORT

#2. DRAFT VERSION OF IG REPORT

Q+A to comp

① memo → contractors

②

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

Progress
prog memo
to contractors

DATE: OCT 27 1998

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Fiscal Intermediary Fraud Units," (OEI-03-97-00350)

We welcome the suggestions in the above-referenced report that provides national information on the performance of fiscal intermediary fraud units. We appreciate OIG's efforts to help us strengthen the monitoring and oversight of fraud unit efforts.

The data collected for the report covered fiscal year (FY) 1996. Beginning in 1997, the Health Care Financing Administration (HCFA) mandated that fiscal intermediaries (FIs) use the HCFA Customer Information System as a fraud detection tool. The tool will enable the FIs to proactively identify fraud. In addition, during FY 1999, HCFA contractors will attend OIG regional training sessions that will further educate them about the proper development of cases to be referred to law enforcement agencies.

We concur with the report's recommendations. Our specific comments follow:

OIG Recommendation #1
HCFA should improve the contractor performance evaluation system so that it not only encourages continuous improvement, but also holds contractors accountable for meeting specific objectives.

HCFA Response
We concur and plan to develop specific national objectives to be evaluated during FY 1999. In September 1998, we visited 13 contractor fraud units to gather information that will help us develop ambitious, but practical, objectives. In addition, HCFA through its contractor has just completed gathering the requirements to be used in the design of a new program integrity management information system. The process required that the data metrics needed to evaluate Medicare contractor medical review and benefit integrity effectiveness be identified before building the new system. A contract has been let to build the new system.

HCFA Response

We concur. In March 1998, HCFA convened a national conference to identify best practices in fighting waste, fraud, and abuse. The conference brought together representatives from Medicare contractors, private industry, law enforcement, health care providers, and beneficiaries, in order to discuss ways to combat fraud. HCFA listened to these experts, and we are working to incorporate their effective methods into our own program integrity strategy.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

OFM
J. Davis
1330

Date AUG 24 1998

From June Gibbs Brown
Inspector General

Subject OIG Draft Report: "Fiscal Intermediary Fraud Units," OEI-03-97-00350

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

Attached for your review and comment is our draft inspection report on fiscal intermediary fraud units. We found that fiscal intermediary fraud units differed substantially in the number of complaints and cases handled. Some units produced few, if any, significant results. While one would expect units of different size and resources to handle different size workloads, we found units of similar size and resources handling substantially different workloads.

We also found that despite the Health Care Financing Administration's (HCFA) expectation that the units proactively identify fraud, half of them did not open any cases proactively. In addition, more than one-third of the units did not identify program vulnerabilities even though this heads the list of responsibilities for fraud units in the Medicare Intermediary Manual. We found that key words and terms related to fraud unit work vary in meaning and this hinders HCFA's ability to interpret fraud unit data and measure fraud unit performance.

We make several recommendations to strengthen HCFA's monitoring and oversight of fraud unit efforts to identify fraud and abuse.

We would appreciate receiving your comments on the draft report within 45 days of the date of this memorandum.

If you have any questions or comments about this report, please call me or George Grob, Deputy Inspector General for Evaluation and Inspections, or have your staff contact Mary Beth Clarke at (202) 619-2481.

Attachment

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INTRODUCTION

PURPOSE

The purpose of this report is to provide national information on fiscal intermediary fraud units.

BACKGROUND

Fiscal Intermediaries

Fiscal intermediaries are companies under contract with the Health Care Financing Administration (HCFA) to administer a major part of the Medicare program. As a group, fiscal intermediaries have responsibility for processing 75 percent of Medicare payments. Other contractors called carriers process the remaining 25 percent. In 1996, fiscal intermediaries processed $130 billion in Medicare payments.[1] Intermediaries pay for inpatient services under Medicare Part A, and certain types of outpatient claims under Medicare Part B. The types of providers billing intermediaries are: hospitals, skilled nursing facilities, home health agencies, rural health clinics, renal dialysis centers, federally qualified health centers, rehabilitation facilities, community mental health centers, and hospices. Individual fiscal intermediaries vary in the amount of Medicare claims and payments they process.

Fraud Units

Fraud units are part of HCFA's overall Medicare integrity program. As of 1993, HCFA required all fiscal intermediaries and carriers to have distinct units to detect and deter Medicare fraud. In 1996, HCFA budgeted 20 percent of its program integrity dollars to fiscal intermediary fraud units and 80 percent to carrier fraud units. From 1993 through 1997, funding was based mainly on the contractors' claim volume. However, in fiscal year 1998, HCFA changed the funding methodology to take into account the contractors' workload, risk, and performance.[2]

Fraud units differ in human and financial resources as well as workload. However, regardless of differences, they all must meet requirements outlined in the Medicare Intermediary Manual. According to the Manual (Section 3950ff), fraud units are expected to:

- identify program vulnerabilities;
- proactively identify fraud within their service area and take appropriate action;
- determine factual basis of complaints of fraud made by beneficiaries, providers, HCFA, Office of Inspector General (OIG), and other sources;
- explore fraud leads in their jurisdiction;
- initiate action to deny or suspend payments where there is reliable evidence of fraud;
- develop cases and refer them to the OIG for consideration of civil and criminal prosecution and/or application of administrative sanctions; and
- provide outreach to providers and beneficiaries.

The HCFA also has other expectations of the fraud unit. For example, all fraud units must enter their fraud cases in the national Fraud Investigation Database. The database was created by HCFA and implemented in May 1996. It tracks contractors' cases of fraud and abuse. It is meant to be an information sharing tool for Medicare, Medicaid, and law enforcement agencies, including the OIG, Federal Bureau of Investigations, and Department of Justice. Also, HCFA has stressed that fraud units should develop fraud cases through proactive data analysis, and not use complaints as the sole driver of case development.

Oversight of Fraud Units

The HCFA regional offices have oversight authority for the contractor fraud units in their regions. They stay in touch with fraud unit staff, oversee the Fraud Investigation Database, and collect various mandatory reports (e.g., quarterly workload reports) from the fraud units. The regional HCFA staff conduct annual or biennial performance evaluations of each fraud unit. They give the fraud unit a written evaluation report, pointing out areas where the unit has improved from the previous evaluation and where the unit has weaknesses. Emphasis is on continuous improvement. Copies of evaluation reports are sent to HCFA Central Office.

New Program Safeguard Contractors

The HCFA is currently planning to separate future anti-fraud activities from other carrier and fiscal intermediary operations. These activities will become the purview of new contractors to be known as program safeguard contractors. A time line and other details related to this plan (e.g., the number of new contractors and geographical area of jurisdiction) have not yet been determined.[3]

National Study of Fiscal Intermediary Fraud Units and Related OIG Studies

This study is the first national evaluation of fiscal intermediary fraud units since their creation in fiscal year 1993. Our national study of carrier fraud units was issued in November 1996 *(Carrier Fraud Units, OEI-05-94-00470)*. In August 1995, we issued a study of HCFA's new approach to monitoring contractors' program integrity efforts (*Monitoring Medicare Contractor Performance: A New Approach, OEI-01-93-00160)*.

SCOPE AND METHODOLOGY

We surveyed all 41 fiscal intermediaries that were under contract in 1996 and still under contract in 1998. We selected fiscal year 1996 as the period for our study because it was the most recent year for which a complete year of fraud unit workload data were available. In the text and tables of this report, complaint and case workload data represents fiscal year 1996. These workload data include complaints and cases that were open during any part of fiscal year 1996.

Fraud Unit Information

Our primary data collection instrument was a self-administered questionnaire. It was mailed to all fraud unit managers, and all fraud units responded. We also telephoned the fraud units to answer any questions they might have about the intent of the questionnaire and the definition of terms used. When incomplete questionnaires were returned to us, we contacted the fraud units for clarification. We did not, however, independently verify the responses.

The questionnaire was developed with assistance from HCFA staff in Central Office and Region III as well as a fiscal intermediary fraud unit manager. These individuals provided insight as to the variety of fraud unit operations and the kind of data that should be available from all units. They also provided advice on question wording, layout, and definition of terms. The program integrity staff in HCFA Central Office gave us the definitions for the terms "complaint" and "case," and we used their definitions with minor paraphrasing. A complaint is an allegation of fraud or abuse committed by a provider, beneficiary, or other individual or entity against the Medicare program. A case is expanded data collection and analysis performed on (1) substantiated complaints, or (2) proactively identified fraud or abuse.

While most fraud units handle complaints as well as cases, and while complaints may lead to the collection of overpayments, our questionnaire contained few questions about complaints. Complaints frequently turn out to be misunderstandings or billing errors, not fraud or abuse. Therefore, we limited complaint questions to the issue of complaint volume in the fraud unit workload.

In addition to collecting data from the fraud units, we collected data from HCFA regarding Medicare payment amounts, claim volume, and fraud unit funding. In order to compare fraud units of similar size, we arrayed the 41 intermediaries by the amount of their 1996 Medicare payments. We did not use claim volume as a size indicator because HCFA's database did not contain claim volume for two of the 1996 intermediaries. In any case, Medicare payments and claim volume were generally correlated. We then grouped the intermediaries into large, medium, and small categories, as shown in the table below.

We calculated the totals and medians for key variables within the large, medium, and small categories including: fiscal intermediary Medicare payments, fraud unit budget, full-time-equivalent (FTE) staff, complaint volume, case volume, number of fraud unit cases opened proactively, number of cases referred to the OIG, and number of program vulnerabilities identified. Hereinafter, when we refer to large, medium, and small fraud units, we are referring to the units in the intermediary size categories shown in the table below.

SIZE CATEGORY	# OF INTERMEDIARIES	RANGE OF 1996 MEDICARE PAYMENTS
LARGE	11	Over $4 billion
MEDIUM	18	Between $1 and $4 billion
SMALL	12	Less than $1 billion

Review of Contractor Performance Evaluations

In addition to the fraud unit questionnaire, we collected contractor performance evaluations for 1995, 1996, and 1997. Between 1995 and 1997, HCFA conducted at least one evaluation for 40 of the 41 fraud units in our study. Most of the evaluation reports were sent to us by the fraud units. The remainder came from HCFA.

We reviewed one evaluation report for each fraud unit evaluated between fiscal years 1995 and 1997. Since all fraud units are not evaluated annually, we reviewed as many as possible (22) for our study year. We then sought evaluations from 1997 (5) and then from 1995 (13) for a total of 40 evaluations. We examined the following variables in each evaluation report: cases, complaints, proactive data analysis, and identification of program vulnerabilities.

This study was conducted in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

FRAUD UNITS DIFFERED SUBSTANTIALLY IN THE NUMBER OF COMPLAINTS AND CASES HANDLED. SOME FRAUD UNITS PRODUCED FEW, IF ANY, SIGNIFICANT RESULTS.

While one would expect fraud units of different size and resources to handle different size workloads, we found units of similar size and resources handling substantially different workloads. We also found some small fraud units that had greater workloads than larger units with more resources. In addition, some fraud units did not develop any cases or send any case referrals to the OIG.

Fraud units handled between 3 and 1,892 complaints per unit.

A total of 17,796 complaints were handled by 39 fraud units. Two of the 41 fraud units reported that they did not handle complaints. In those two instances, the fiscal intermediary had other staff screening complaints, and the fraud unit handled only cases.

As shown in the table below, the range of complaints handled by fraud units of similar size is quite broad. Among large fraud units, the unit with the highest complaint workload handled eight times more complaints than the unit with the smallest workload. Among medium and small units, the largest workload of complaints was 20 and 100 times greater than the smallest workload.

Range of Complaints Handled by Fraud Units of Similar Size

Size Category	Number of Fraud Units	Highest # of Complaints Handled	Lowest # of Complaints Handled	Median # of Complaints Handled
Large	11	1,892	223	795
Medium	18	1,508	74*	311*
Small	12	357	3	63

*Does not include the two fraud units that did not handle complaints.

Not only were there significant differences among fraud units within the same size category but unexpected differences were also found between categories. In the aggregate, as evidenced by the median number of complaints (see table above), larger units tended to handle more complaints than smaller units. However, one small fraud unit had more complaints than three of the large fraud units and twelve of the medium-sized units. The table on the next page lists each unit by size, and provides data regarding intermediary Medicare payments and fraud unit resources, complaint workload, and case workload.

Variability in Large, Medium, and Small Fraud Units

	ID#	Medicare Payments	Fraud Unit Budget	Fraud Unit FTEs	Fraud Unit Complaints	Fraud Unit Cases
Large	1	$10,013,524,077	$428,100	8.25	1696	168
	2	$9,574,962,625	$612,300	6	1892	12
	3	$8,156,383,788	$359,000	2.5	802*	45*
	4	$6,125,735,620	$353,452	3.75	795	564*
	5	$5,860,334,858	$374,128	7.25	1750	259
	6	$5,698,345,959	$486,534	5	371	365*
	7	$5,138,463,636	$360,200	3	223	128
	8	$4,695,746,722	$363,000	7	1277	18
	9	$4,266,043,734	$518,300	6	307	236
	10	$4,205,559,254	$402,000	3.5	250	78
	11	$4,164,323,154	$512,680	8.25	385	192
Medium	12	$3,946,244,913	$45,760	1.75	88	0
	13	$3,528,029,526	$231,800	3.5	699	50
	14	$3,046,336,774	$217,600	3	240	3
	15	$3,033,310,183	$249,400	2.75	559	15
	16	$2,825,729,802	$125,640	2	74	6
	17	$2,714,180,846	$155,809	3	646	31*
	18	$2,687,677,846	$145,800	3	250	25
	19	$2,413,141,222	$111,508	3	935	625
	20	$2,409,518,487	$142,100	1.5	158	11
	21	$2,049,178,456	$100,000	2.5	402	79
	22	$1,619,800,963	$87,993	1.75	0	285
	23	$1,600,681,825	$156,470	1.75	320	22
	24	$1,544,764,282	$107,900	1.25	0	65
	25	$1,246,209,143	$74,248	1.5	307*	190*
	26	$1,132,721,108	$109,600	2	157	2
	27	$1,093,918,076	$81,600	1	1508	83
	28	$1,066,891,562	$50,953	1.5	314	246*
	29	$1,063,221,043	$103,700	1	193	0
Small	30	$993,720,360	$74,100	2.25	357	46
	31	$986,682,696	$55,000	1.5	116	40
	32	$940,136,850	$97,035	2.5	242	35
	33	$573,157,206	$62,600	2	158	1
	34	$501,923,887	$45,800	2	123	7
	35	$461,651,557	$58,200	1	9	51
	36	$418,758,568	$79,300	1.5	24	13
	37	$318,344,371	$34,218	1.25	97	1
	38	$300,584,905	$7,841	1.25	3	9
	39	$287,546,633	$4,400	0.5	28	1
	40	$258,659,723	$40,400	0.5	27	1
	41	$109,546,573	$15,400	0.25	14	0
	TOTAL	$113,071,692,814	$7,641,669	112.75	17,796	4,008

* Workloads estimated by fraud units.

The number of cases handled by each fraud unit ranged from 0 to 625.

Nationally, fraud units handled a total of 4,008 cases. Of the 41 fraud units, 3 did not have any cases. As shown in the table below, the difference between the fraud units with the highest and lowest cases handled in each category is extreme.

Range of Cases Handled by Fraud Units of Similar Size				
Size Category	Number of Fraud Units	Highest # of Cases Handled	Lowest # of Cases Handled	Median # of Cases Handled
Large	11	564	12	168
Medium	18	625	0	28
Small	12	51	0	8

Variation among individual fraud units could not always be explained by size or resources (see table on page 6). For example, of the three fraud units with zero cases, two were medium fraud units and one was small. In addition, the fraud unit with the largest caseload (625) was a medium unit. This unit had one-third the fraud budget of any large fraud unit and less staff than most large units. Another example is that 60 percent of the medium units and 25 percent of the large units handled fewer cases than one of the small fraud units. Moreover, the large fraud unit with the least number of cases (12) had the highest budget and 6 FTEs. In contrast to this, the large fraud unit with the highest caseload (564) had the smallest budget and fewer staff.

Fraud units referred between 0 and 102 cases to the OIG.

Fraud units are required to develop cases and refer them to the OIG for consideration of civil and criminal prosecution and/or the application of administrative sanctions. The fraud units referred a total of 346 cases to the OIG in 1996 (9 percent of the national case workload).

Ten fraud units (5 medium and 5 small units) made no referrals to the OIG. Out of 41 fraud units, 27 (or 66 percent) referred three or fewer cases. Nearly half of fraud units referred less than 5 percent of their cases to the OIG. Table 1 in Appendix A provides a list of all fraud units in large, medium, and small categories, and shows the number and percent of each unit's case workload that was referred to the OIG.

As with complaint and case workloads, the number of case referrals to the OIG differed among fraud units of similar size. For example, although 79 percent of cases referred to the OIG (273 of 346) were from large fraud units, there was a wide disparity among individual units in this category. One large unit was responsible for nearly 30 percent of all cases referred to the OIG (102 of 346). This was twice as many as the unit with second highest number of referrals (51 of 346). In contrast, four large units referred seven or fewer cases each.

Between size categories, several smaller fraud units referred more cases than larger units. For instance, one medium unit referred more cases than over half (7 of 11) of the larger units.

Another example is that one small unit referred more cases than three-quarters of the medium units and one-quarter of the large units.

Overall, 56 percent of the 346 referred cases were accepted by the OIG. Another 16 percent were referred by the OIG to other law enforcement agencies. Nine percent of the cases were returned to the fraud units for administrative closure, and 1 percent were returned for further development. The fraud units could not provide the status of the remaining 18 percent of referred cases. Individual fraud units had OIG acceptance rates ranging from 0 to 100 percent of cases. Table 2 in Appendix A provides the number and status of cases fraud units referred to the OIG.

DESPITE HCFA'S EXPECTATION THAT FRAUD UNITS PROACTIVELY IDENTIFY FRAUD, HALF OF THE UNITS DID NOT OPEN ANY CASES PROACTIVELY.

Overall, fraud units developed few cases proactively. Even though HCFA emphasizes the importance of doing proactive work, most cases were developed in reaction to complaints. Of the 4,008 fraud unit cases, only 5 percent (184) were opened as a result of proactive case development. Fifty-one percent of fraud units (21 of 41) did not open any cases proactively. Furthermore, the fraud unit opening the largest number of proactive cases (97) was responsible for more than half the national total. The unit with the second highest number of proactive cases had 24, and the unit with the third highest number had 10. These three units alone opened 71 percent of the proactive cases. Rarely did the size of the fiscal intermediary, or the resources of the fraud unit correlate to the number of cases opened proactively. For example, half the large, medium, and small fraud units had no such cases, and one small fraud unit had seven (see Appendix A, Table 3).

Ninety percent of fraud units (37 of 41) said they used proactive methods in their attempt to uncover fraud and abuse. Yet, only half of these units (20 of 37) opened any cases proactively. Seventeen units that said they used proactive methods did not open cases as a result of their proactive work.

The most commonly used proactive method was data analysis. Used by 80 percent of fraud units, proactive data analysis was used to open 72 percent of proactive cases (133 of 184). Proactive data analysis is defined as using data to identify fraud leads by looking for patterns, trends, or aberrancies versus using data solely to expand the scope of an investigation. The second most common method of proactively identifying fraud was networking with other intermediary units and with external entities. Used by 56 percent of fraud units, networking was used to open 21 percent of proactive cases (38 of 184). Table 4 in Appendix A lists the proactive methods used by fraud units, the number and percent of units that used each method, and the number of times the method was used to open cases.

In our review of the units' contractor performance evaluations, we found that 80 percent of the evaluation reports (32 of 40) addressed the subject of using proactive methods to identify fraud. In addition, 65 percent (26 of 40) specifically noted whether or not the unit had conducted any proactive data analysis. However, only 50 percent (20 of 40) reminded the fraud units that they are expected to conduct proactive data analysis to identify potential fraud cases.

MORE THAN ONE-THIRD OF FRAUD UNITS DID NOT IDENTIFY PROGRAM VULNERABILITIES.

The identification of program vulnerabilities heads the list of fraud unit responsibilities in the Medicare Intermediary Manual. Yet 39 percent of fraud units (16 of 41) did not identify any. In addition, fraud units are not required to keep track of identified program vulnerabilities.[4] At least one fraud unit that identified vulnerabilities had to rely on memory to describe them.

In our review of the contractor performance evaluations, we found that few HCFA reviewers addressed the importance of identifying program vulnerabilities. Only 10 percent of evaluation reports (4 of 40) stated whether or not the fraud unit identified any program vulnerabilities, and only 18 percent (7 of 40) reminded the fraud unit they are expected to identify them.

Sixty-one percent of fraud units (25 of 41) identified a total of 61 program vulnerabilities. The number of vulnerabilities identified by these units ranged from 1 to 5 (see Appendix A, Table 3). Based on fraud unit descriptions of the vulnerabilities, 52 percent (32 of 61) seemed to be systematic problems that make the Medicare program vulnerable to abuse, such as, loose guidelines that promote inappropriate billing for a service. Another 41 percent (25 of 61) were described as instances of wrongdoing, such as, billing a non-covered service as a covered service. The remaining 7 percent (4 of 61) were simply described as types of providers, such as, an assisted living facility or a community mental health center.

KEY WORDS AND TERMS RELATED TO FRAUD UNIT WORK VARY IN MEANING. THIS HINDERS HCFA'S ABILITY TO INTERPRET FRAUD UNIT DATA AND MEASURE FRAUD UNIT PERFORMANCE.

The HCFA and fraud unit staffs have work-related terms which help them communicate about program integrity operations and performance outcomes. This specialized language is necessary in order to quickly convey meaning about complex subjects. Many of the words and terms do not sound like specialized terms because they are also used in common speech, e.g., "complaint," "case," "program vulnerability" and "overpayment." However, for Medicare fraud control, these words have special meanings. For example, a "complaint" is not simply an expression of discontent, it is an allegation of fraud or abuse. In addition, among fraud unit and HCFA staff, meanings of key words can vary depending on who is using them and the context in which they are used.

The variety of meanings for key terms is a problem in the Medicare integrity program because it hinders HCFA's ability to interpret the data it receives from fraud units and its regional oversight staff. In addition, there are potential problems when HCFA and fraud units share data with one another or collaborate with other fraud control entities. Furthermore, differences in the use of key terms in contractor performance evaluations make performance measurement with this tool difficult if not impossible. These shortcomings are likely to hamper HCFA's effectiveness in making funding decisions or selecting future program safeguard contractors.

Below we discuss a few key terms that vary in meaning and, consequently, can hinder HCFA in its ability to interpret data and measure performance.

Complaints and cases

Complaints and cases represent two very different types of workload, yet the terms are often used interchangeably and sometimes are tracked as one type of workload. In our fraud unit questionnaire, we required fraud units to (1) distinguish complaints from cases when they quantified their workload, and (2) use the definitions for case and complaint given in the questionnaire. The purpose of these requirements was to ensure data integrity. However, this posed a problem for several fraud units. For example, it was necessary for some fraud units to estimate their workload numbers because they had one computer tracking system that did not distinguish cases from complaints.

In addition, the terms case and complaint were also confused in contractor performance evaluations. In 43 percent of the evaluation reports (17 of 40), the words case and complaint were used interchangeably. Moreover, we found inconsistencies in the way the words case and complaint were used in the Medicare Intermediary Manual (section 3966), and in certain HCFA guidelines for reporting fraud unit activities.

Program vulnerabilities

The Medicare Manual (section 3953) directs fraud units to "identify Medicare and intermediary policies and procedures that may make Medicare vulnerable to fraud and abuse." A shorter way of saying this is that fraud units should identify program vulnerabilities. However, the term "program vulnerability" is another key term that has more than one interpretation. As we mentioned previously, fraud units identified 61 program vulnerabilities. Yet, all the vulnerabilities fraud units described were not systematic problems which make Medicare vulnerable to fraud and abuse. Forty-one percent of them (25 of 61) were described as instances of wrongdoing by a provider, and 7 percent (4 of 61) were described as types of providers.

Overpayments

Responses to our fraud unit questionnaire suggest that the word overpayment may have various meanings in the context of contractor operations and fraud unit cases. In general, overpayments are Medicare funds that providers receive in excess of amounts owed to them, but we did not provide this definition in our questionnaire. We asked the fraud units to list their cases where overpayments were identified (not recovered) in fiscal year 1996. Our analysis found that fraud units identified overpayments in only 15 percent of the national case workload (610 of 4,008) and in 36 percent of cases referred to the OIG (124 of 346) even though the Manual (section 3968) states that identifying overpayments is part of the case development process.

It is conceivable that fraud units were defining the term overpayment in one of two ways when answering our question: (1) as the actual amount of money they requested back from providers, or (2) the amount of money at risk associated with a fraud case. If some fraud units used the first definition, it is possible that they would not have listed an overpayment amount for this question. However, it is also possible that the fraud units were unable to determine or track the risk associated with fraud cases.

RECOMMENDATIONS

The HCFA and fiscal intermediary fraud units have significant responsibilities in identifying and deterring fraud in a part of the Medicare program where $130 billion is at risk. The variation in fraud detection, especially among units with similar resources, raises concern about possible poor performance by some fraud units.

Although HCFA currently conducts performance evaluations of fraud units, we believe there is a need to strengthen the monitoring and oversight of contractors' efforts to identify fraud and abuse. In recent years, HCFA has focused on continuous improvement as a method of evaluating contractor performance. In light of the disparity in fraud detection among contractors, the agency may need to refocus its evaluation efforts to include some type of return on investment analysis.

In order that HCFA may have a better understanding of fraud unit performance, which in turn will lead to making better decisions about fraud unit funding, selecting future contractors, and working collaboratively with other anti-fraud entities, we recommend that HCFA:

- Improve the contractor performance evaluation system so that it not only encourages continuous improvement, but also holds contractors accountable for meeting specific objectives.

- Require that all contractor performance evaluations list HCFA's national and regional objectives and address whether or not the fraud unit is meeting those objectives.

- Establish a standard set of data that can be used to measure fraud units' performance in meeting established objectives. Require that all contractor performance evaluation reports contain this data.

- Establish clear definitions of key words and terms (e.g., complaint, case, program vulnerability, and overpayment). Disseminate definitions and require that HCFA program integrity staff and fraud unit staff use the same definitions. In a future update of the Medicare Intermediary Manual, revise sections so that these words are consistently used to mean the same thing.

- Provide opportunities for fraud units to exchange ideas, compare methods, and highlight best practices relating to fraud and abuse detection.

ENDNOTES

1. The 41 fiscal intermediaries in our study processed $113 billion in Medicare payments in 1996.

2. The Health Care Financing Administration's funding of all Medicare fraud control activities since the passage of the Health Insurance Portability and Accountability Act of 1996, is discussed in the U.S. General Accounting Office's report, *Medicare: HCFA's Use of Anti-Fraud-and-Abuse Funding and Authorities (GAO/HEHS-98-160)*, issued June 1998.

3. In April 1998, the Health Care Financing Administration issued, for public comment, a Draft Scope of Work regarding Program Safeguard Contractors. At that time, the agency anticipated it would have a Request for Proposal ready by July 1998. However, as of this writing, a Request for Proposal has not been issued.

4. Nowhere in section 3950ff of the Medicare Intermediary Manual is there a requirement to track the number or kind of program vulnerabilities that fraud units identify.

APPENDIX A

Table 1: Fraud Unit Cases Referred to the OIG in FY 1996

	ID#	Total Cases FY 1996	Number of Cases Referred to the OIG	Cases Referred as a Percent of Total Cases
Large	1	168	3	2%
	2	12	3	25%
	3	45*	21	47%
	4	564*	17	3%
	5	259	51	20%
	6	365*	16	4%
	7	128	102	80%
	8	18	7	39%
	9	236	15	6%
	10	78	3	4%
	11	192	35	18%
Medium	12	0	0	-
	13	50	0	0%
	14	3	3	100%
	15	15	0	0%
	16	6	3	50%
	17	31*	4	13%
	18	25	3	12%
	19	625	5	1%
	20	11	3	27%
	21	79	3	4%
	22	265	0	0%
	23	22	3	14%
	24	65	2	3%
	25	190*	20	11%
	26	2	2	100%
	27	83	1	1%
	28	246*	5	2%
	29	0	0	-
Small	30	46	4	9%
	31	40	1	3%
	32	35	5	14%
	33	1	1	100%
	34	7	0	0%
	35	51	3	6%
	36	13	1	8%
	37	1	1	100%
	38	9	0	0%
	39	1	0	0%
	40	1	0	0%
	41	0	0	-
	TOTAL	4,008	346	9%

* Workloads estimated by fraud units.

Table 2: Disposition of Fraud Unit Cases Referred to the OIG in FY 1996

	ID #	Cases Referred to the OIG	Cases Accepted by the OIG	Cases Referred by OIG to Other Law Enforcement	Cases Returned to Fraud Unit for Further Development	Cases Returned to Fraud Unit for Administrative Handling	Cases Where Status was Unknown
Large	1	3	2	0	0	1	0
	2	3	0	1	0	2	0
	3	21	15	0	0	0	6
	4	17	16	0	0	1	0
	5	51	11	2	0	1	37
	6	16	6	3	0	3	4
	7	102	98	0	0	2	2
	8	7	0	5	0	0	2
	9	15	5	0	1	6	3
	10	3	0	2	0	0	1
	11	35	13	18	0	3	1
Medium	12	0	-	-	-	-	-
	13	0	-	-	-	-	-
	14	3	0	3	0	0	0
	15	0	-	-	-	-	-
	16	3	1	2	0	0	0
	17	4	0	3	1	0	0
	18	3	1	0	0	0	2
	19	5	1	1	0	3	0
	20	3	2	1	0	0	0
	21	3	2	1	0	0	0
	22	0	-	-	-	-	-
	23	3	0	1	1	1	0
	24	2	2	0	0	0	0
	25	20	9	2	0	6	3
	26	2	2	0	0	0	0
	27	1	1	0	0	0	0
	28	5	0	4	0	1	0
	29	0	-	-	-	-	-
Small	30	4	4	0	0	0	0
	31	1	1	0	0	0	0
	32	5	1	3	0	0	1
	33	1	0	0	1	0	0
	34	0	-	-	-	-	-
	35	3	1	1	0	1	0
	36	1	1	0	0	0	0
	37	1	0	1	0	0	0
	38	0	-	-	-	-	-
	39	0	-	-	-	-	-
	40	0	-	-	-	-	-
	41	0	-	-	-	-	-
	TOTAL	348	195	54	4	31	62
	% OF CASES REFERRED	100%	56%	16%	1%	9%	18%

Table 3: Proactive Cases Opened and Program Vulnerabilities Identified

Size	ID#	Medicare Payments	Fraud Unit Budget	Fraud Unit FTEs	Total Fraud Unit Cases	Proactive Cases**	Program Vulnerabilities
Large	1	$10,013,524,077	$428,100	6.25	168	4	3
	2	$9,574,962,625	$612,300	6	12	1	0
	3	$8,156,383,788	$359,000	2.5	45*	0	3
	4	$6,125,735,620	$353,452	3.75	564*	0	5
	5	$5,860,334,858	$374,128	7.25	259	4	0
	6	$5,698,345,959	$486,534	5	365*	10	4
	7	$5,138,463,636	$360,200	3	128	97	3
	8	$4,695,746,722	$363,000	7	18	0	1
	9	$4,266,043,734	$518,300	6	236	0	2
	10	$4,205,559,254	$402,000	3.5	78	6	2
	11	$4,164,323,154	$512,680	8.25	192	0	2
Medium	12	$3,946,244,913	$45,760	1.75	0	0	0
	13	$3,528,029,526	$231,800	3.5	50	6	1
	14	$3,046,336,774	$217,600	3	3	0	0
	15	$3,033,310,183	$249,400	2.75	15	0	2
	16	$2,825,729,802	$125,640	2	6	3	0
	17	$2,714,180,846	$155,809	3	31*	3	3
	18	$2,687,677,846	$145,800	3	25	0	1
	19	$2,413,141,222	$111,508	3	625	0	0
	20	$2,409,518,487	$142,100	1.5	11	3	1
	21	$2,049,178,456	$100,000	2.5	79	0	0
	22	$1,619,800,963	$87,993	1.75	285	24	1
	23	$1,600,681,825	$156,470	1.75	22	0	2
	24	$1,544,764,282	$107,900	1.25	65	0	0
	25	$1,246,209,143	$74,248	1.5	190*	2	5
	26	$1,132,721,108	$109,600	2	2	0	0
	27	$1,093,918,076	$81,600	1	83	2	0
	28	$1,066,891,562	$50,953	1.5	246*	5	4
	29	$1,063,221,043	$103,700	1	0	0	0
Small	30	$993,720,360	$74,100	2.25	46	2	0
	31	$986,682,696	$55,000	1.5	40	7	1
	32	$940,136,850	$97,035	2.5	35	0	2
	33	$573,157,206	$62,600	2	1	0	0
	34	$501,923,887	$45,800	2	7	0	0
	35	$461,651,557	$58,200	1	51	1	3
	36	$418,758,568	$79,300	1.5	13	1	2
	37	$318,344,371	$34,218	1.25	1	0	0
	38	$300,584,905	$7,841	1.25	9	2	2
	39	$287,546,633	$4,400	0.5	1	1	4
	40	$258,659,723	$40,400	0.5	1	0	0
	41	$109,546,573	$15,400	0.25	0	0	2
	TOTAL	$113,071,692,814	$7,641,869	112.75	4,008	184	61

* Workloads estimated by fraud units.

** Proactive cases are a subset of total fraud unit cases.

Table 4: Fraud Unit Use of Proactive Methods to Identify Fraud and Abuse

PROACTIVE METHOD [1]	Number of Fraud Units Using Method N=41	Percent of Fraud Units Using Method	Number of Times Proactive Method was Used to Open Cases [2]
Data Analysis	33	80%	133
Internal and External Networking	23	56%	38
Look for Patterns and Trends (Not Data Analysis)	10	24%	11
Conduct Research and Analysis on Fraud Alerts	8	20%	1
Conduct Medical Review	7	17%	10
Conduct and Receive Training	5	12%	0
Expand Case	5	12%	5
Monitor (e.g.,Edits and Audits)	5	12%	1
Conduct Education or Outreach	4	10%	0
Review News Media	4	10%	1
Survey Providers	4	10%	2

1. Except for "Data Analysis," all other proactive methods were identified by the fraud units themselves.
2. The total for this column (202) differs from the total number of cases opened proactively (184) because more than one proactive method could have been used to open each case.

HEALTH CARE FINANCING ADMINISTRATION

ADDRESSEE:	FROM: Corinne Marvin for Nancy-Ann
Chris Jennings / Devore	OFFICE OF THE ADMINISTRATOR 200 INDEPENDENCE AVE., S.W. ROOM 314G WASHINGTON, DC 20201
PHONE: 456-5560	PHONE: 202-690-6726 FAX : 202-690-6262

TOTAL PAGES:	ADDRESSEE'S FAX MACHINE NUMBER:	DATE:
C+10	456–	10/22/98

REMARKS:

We think this is the final version of the letter. Please call Jack Hoadley (401-8401) or me if you have any questions.

Thanks,

Corinne

From: JACK HOADLEY <jhoadley@OSASPE.DHHS.GOV>
To: Washington.DC1(CMarvin,KKing)
Date: 10/22/98 10:04am
Subject: Thursday's revision -- CORRECT VERSION ATTACHED

IGNORE ATTACHMENT ON PREVIOUS MESSAGE -- THIS HAS THE
CORRECT VERSION ATTACHED.

Here is the new (final?) version of the letter (marked 10/22).
(Reminder
-- Chris Jennings wanted to see the final version before it goes
out)

The changes of note are as follows (marked in redline):

-- some words added to the "Applicability" paragraph to make the
policy
clearer, in response to Chris Jennings.

-- a couple of new sentence, per Gary, on explaining what we mean
by
nondiscrimination in price

-- a new sentence, per Michael McMullen and others, encouraging
states
to go beyond what is required

-- a corrected sentence, per Michael McMullen (and Don Kosin),
correcting a reference to ESRD benes.

-- an addition to the outreach paragraph in the attachment, per
Chris
Jennings, to give a bit more detail -- specifically a listing of
some of the
partner organizations. (I left Jim Bossenmeyer a voicemail
asking for a
list to use -- it needs to be added to the paragraph --
presumably would
note beneficiary groups, health plans, SHIPs, ...)

PHOTOCOPY
PRESERVATION

DRAFT
10/22/98 - a.m.

Dear Insurance Commissioner:

I am writing to inform you of new requirements contained in the Balanced Budget Act of 1997 (the BBA) which apply to Medicare Supplement ("Medigap") insurance policies. These provisions were enacted at the same time as creation of the new Medicare+Choice program, which changes and expands health care options for Medicare beneficiaries. The new provisions strengthen the rights of beneficiaries who are involuntarily terminated from Medicare managed care plans (and certain beneficiaries who leave HMOs voluntarily) to obtain Medigap coverage if they return to original Medicare.

This protection will be particularly important in the next few months, because, as you probably know, the Health Care Financing Administration (HCFA) has been notified recently by a number of HMOs serving portions of 30 States and the District of Columbia that they will no longer serve some or all of their current Medicare enrollees. A small percentage of beneficiaries may be left with no HMO plan option and will need to transition back to original Medicare with Medigap, while a number of others who are losing their HMO coverage may also wish to return to original Medicare with Medigap.

We are committed to trying to guard beneficiaries from undue concern and unnecessary hardship as they make this transition. However, in order to protect these vulnerable individuals, we **urgently request your cooperation in immediately alerting Medigap issuers in your State to the need to comply with the new Federal requirements.**

I call your attention to two key issues, which are further explained below. First, the rights established by the BBA apply to most Medicare beneficiaries, including many who are eligible for Medicare based on disability or end-stage renal disease (ESRD). Second, there are both State and Federal enforcement mechanisms that apply to these rights.

Section 4031 of the BBA mandates several new situations in which Medicare beneficiaries are guaranteed issue of Medigap insurance. Two of these new protections apply to beneficiaries now enrolled in HMOs that are terminating contracts or reducing service areas.

Most beneficiaries whose coverage is terminating have a key protection: **the right to guaranteed issue of any Medigap plans A, B, C, or F that are offered to new enrollees by issuers in your State**. In Massachusetts, Minnesota, and Wisconsin, section 1882(s)(3)(C) of the Social Security Act (added by the BBA) provides that issuers must provide guaranteed issue of policies that are comparable to plans A, B, C, or F. As an alternative, some beneficiaries may qualify to use a second protection guaranteed by the BBA: **if they have been enrolled in their HMO less than 12 months and were never enrolled in any other Medicare HMO, they may return to their previous Medigap policy if the same issuer still sells the policy in the State.**

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In either case, Medigap issuers may not: (1) deny or condition the sale of the policy; (2) discriminate in the pricing of the policy because of the individual's health status, prior history of claims experience, receipt of health care or medical condition; or (3) impose an exclusion for any preexisting condition. (More details on these rights are explained in the "Detailed Background" attachment that is enclosed with this letter).

HMOs will be sending termination notices to all affected Medicare beneficiaries by November 2. While some beneficiaries will have the option of continuing in another HMO, others will not. In order to ensure a seamless transition into a new Medicare+Choice plan or to obtain Medigap coverage in conjunction with returning to original Medicare, beneficiaries will need to make decisions on new options for receiving their Medicare benefits well before their current HMO coverage ends on December 31. Many of these beneficiaries will be contacting Medigap insurers and your Department about Medigap insurance options available to them as they make decisions on their future Medicare coverage options.

As you address these new Federal requirements in your State, we want to advise you of two important considerations in interpreting the provisions in the BBA (again, more details are included in the "Detailed Background" attachment to this letter):

Applicability. The Medigap rights are guaranteed to "individuals" who meet the statutory criteria (e.g., their prior coverage is terminated). **The statute does not distinguish between individuals eligible for Medicare based on age and those whose eligibility is based on disability or end stage renal disease (ESRD).** Issuers must now make plans A, B, C or F – if those plans are offered to new enrollees – available on a guaranteed issue basis without exclusions for preexisting conditions to all Medicare beneficiaries who meet the statutory criteria. This provision, however, does not require that issuers not now offering all four of the designated plans begin to offer them. Nor does it require that issuers not now selling these plans to disabled or ESRD beneficiaries under 65 must start selling to those individuals.

Where policies are sold, it is important to emphasize that the statute mandates that the premium charged must not be established in a way that discriminates based on health status. This means that issuers cannot consider the health status of individual applicants in determining eligibility or premium levels. Issuers must accept these applicants at the same premium rate provided to otherwise similar new applicants with no health problems. Issuers that adjust rates for non-health status factors, such as age or geographic location, can apply those adjustments if done on a nondiscriminatory basis.

Although the BBA did not extend these protections where Medigap issuers are not now selling plans to beneficiaries under 65, we encourage States to find ways to help these beneficiaries, for

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10/22/98 - a.m.

example, by approving policy forms for these beneficiaries on an expedited basis or by urging plans to extend coverage voluntarily.

Enforcement. The BBA mandated a July 1, 1998, effective date for these requirements. Some confusion has resulted from the fact that the statute incorporates two parallel enforcement mechanisms – one State and one Federal.

- States clearly have the primary authority for enforcement of Medigap requirements under their approved regulatory programs. The law, however, recognizes that you may need to make changes to your Medigap regulatory program in order for it to continue to be an approved program under section 1882(b) of the Social Security Act. If changes are required in order for your State to enforce these provisions, the BBA deems your program to continue to be an approved program during a transition period of, in most cases, up to a year after the NAIC adopted its Model Regulation. Shortly, we will publishing a *Federal Register* notice transmitting this Model Regulation to the States.

- Regardless of when State laws and regulations come into conformity with the Federal requirements, section 1882(s)(4) contains a Federal civil monetary penalty that can be imposed independently of any State enforcement mechanisms. HCFA will be developing further guidance to specify these Federal requirements, including more detailed interpretations of the statutory provisions on guaranteed issue and nondiscrimination in pricing. It is essential for Medigap issuers to understand that **the Federal guaranteed issue requirements added to section 1882(s) by the BBA, as well as the Federal civil money penalty enforcement authority in section 1882(s)(4), apply to all Medigap issuers as of the statutory effective date, July 1, 1998.**

We stand ready to work with you and your staff to ensure that Medicare beneficiaries can benefit from the protections that have been afforded them. Staff from our Regional Offices will contact you shortly to follow up on any questions raised by these requirements. In addition, through the regional offices, HCFA has initiated an extensive outreach campaign to help all Medicare beneficiaries understand their rights and options. We encourage you to work with your HCFA Regional Office to identify issues that could serve as barriers to the effective implementation of the Medicare beneficiary protections guaranteed under Federal law.

Sincerely,

Nancy-Ann Min DeParle
Administrator

DRAFT
10/22/98 - a.m.

Enclosures [“DETAILED BACKGROUND,” WHICH REFERS IN TURN TO 3 OTHERS: (1) THE STATE-BY-STATE LIST OF PLANS AND (2) THE MODEL NOTICE TO BENEFICIARIES -- ALSO LIST OF REGIONAL OFFICE CONTACTS]

NOTE: WE DROPPED REFERENCE TO THE SECTIONS OF THE NAIC MODEL REGULATION

cc: All State Medicaid Directors
All HCFA Regional Offices
All HCFA ARMS, DMSO
APHSA
NGA
NAIC
NCSL
SHIPs

DRAFT
10/22/98 - a.m.

DETAILED BACKGROUND

Before the BBA was enacted, the primary managed care option open to Medicare beneficiaries was to enroll in a health maintenance organization (HMO) or similar organization that had contracted with Medicare, under section 1876 of the Social Security Act, to provide Medicare covered services to beneficiaries in return for payment by Medicare. Most of these organizations had "risk" contracts that paid them a monthly amount for each enrolled beneficiary. Others had "cost" contracts or contracts as health care prepayment plans (for Part B services only) that reimbursed the organization's reasonable costs. The BBA eliminates the old risk contract program at the end of 1998 and replaces it with comparable managed care plans under the new Medicare+Choice program enacted as part of the BBA. Beginning in 1999, the primary managed care option available to beneficiaries will be through organizations that enter into contracts under Medicare+Choice. (For simplicity, we will use the terms "HMO" and "managed care plan" interchangeably here.)

Plan Decisions to Terminate Contracts or Reduce Service Areas

HCFA has been notified by more than 100 HMOs that they will not enter into new Medicare+Choice contracts or that they will sign Medicare+Choice contracts for a reduced service area, effective December 31, 1998. Included are HMOs with risk contracts, HMOs with cost contracts, health care prepayment plans, and plans operating as part of the Medicare Choices demonstration. The beneficiaries currently enrolled in these plans will be seeking new options for receiving their Medicare benefits, effective on or before January 1, 1999. Included among these beneficiaries are some who will not have access to another managed care plan, primarily because they live in an area that is no longer served by any Medicare-contracting HMOs. A small number of beneficiaries who have end-stage renal disease (ESRD) (permanent kidney failure) and are enrolled in the terminating managed care plan will be precluded by law from enrolling in a plan offered by another managed care organization. These beneficiaries may enroll in plans offered by the same organization. We have enclosed a list of the counties and numbers of beneficiaries affected in each State (similar information is available on HCFA's Internet Website at www.hcfa.gov).

Information for Affected Beneficiaries

Most Medicare beneficiaries will be able to choose between enrolling in another HMO, or returning to the "Original" Medicare fee-for-service program. When an HMO terminates coverage because it leaves the Medicare program entirely, or reduces the service area covered by its contract, the individuals it has served have certain statutory rights to enroll with a new managed care plan, or to purchase Medigap insurance if they return to "Original" Medicare. However, these rights are time-limited. It is therefore critical that all affected beneficiaries be

given sufficient information about their choices, as soon as possible, to allow them to make the best decision about how to cope with the change in their health care options.

Part of this information will come from the managed care plans. First, under section 1876 of the Social Security Act, the terminating HMO is required to inform enrolled beneficiaries about other Medicare-contracting HMOs, if any, that will be available to them. However, the beneficiaries will generally be required to decide before the end of November whether they wish to enroll under one of these plans. Second, the HMO is still required under the law that pre-dated the new BBA protections to ensure that beneficiaries who wish to return to Original Medicare are protected against out-of-pocket costs related to pre-existing condition exclusions in Medigap policies. This right, which might in some cases be more attractive than the new BBA protections, is also likely to involve a deadline for making a choice.

Finally, the HMO is required by the Medigap provisions at section 1882(s)(3)(D) of the Social Security Act (added by the BBA) to inform beneficiaries of their new rights with respect to purchasing Medigap insurance. A copy of the letter approved by HCFA for use by the HMOs is enclosed for your information. This letter will likely be used by beneficiaries to demonstrate to Medigap issuers that the beneficiaries qualify for the new guaranteed issue protections. In that notice, HCFA is advising beneficiaries who have any problems with Medigap insurers in your State to contact your department.

Medigap Rights Extended by the Balanced Budget Act

The most important protection created by the BBA for Medicare beneficiaries enrolled with an HMO (of any type) that is terminating its contract with Medicare applies to most individuals who are enrolled in that plan at the time the contract terminates. These individuals have the right to **guaranteed issue of any Medigap plans A, B, C, or F** that are offered to new enrollees by issuers in your State. In the three States with waivers (Massachusetts, Minnesota, and Wisconsin), section 1882(s)(3)(C) provides that issuers must provide guaranteed issue of policies that are comparable to plans A, B, C, or F.

The above right applies to individuals by virtue of the involuntary termination of their coverage. However, certain Medicare beneficiaries in the terminating plans may have another, separate basis for entitlement to guaranteed issue of a Medigap policy. In particular, if an individual (1) has been enrolled for less than 12 months with the HMO that is terminating coverage, (2) was never enrolled in any other Medicare HMO, and (3) was previously enrolled in a Medigap policy, the individual may terminate enrollment with the HMO before the contract terminates, and return to the previous Medigap policy if the same issuer still sells the policy in the State. If the policy is no longer available from that issuer, the individual may purchase Medigap plans A, B, C, or F from any issuer which sells those plans in the State.

Note that, if an issuer does not market all four of the specified benefit packages, the Federal law does not require it to add the other policies.

For either of these groups of beneficiaries, an issuer may not:

(1) deny or condition the sale of the policy;

(2) discriminate in the pricing of the policy because of the individual's health status, prior history of claims experience, receipt of health care or medical condition; or

(3) impose an exclusion for any preexisting condition.

These rights are guaranteed to "individuals" who meet statutory criteria (e.g., their prior coverage is terminated). The statute does not distinguish between individuals eligible for Medicare based on age, and those whose eligibility is based on disability or ESRD. As a result of the BBA provision, any issuer now offering plans A, B, C or F to beneficiaries over 65 must make these plans available on a guaranteed- issue basis without exclusions for preexisting conditions to all Medicare beneficiaries who meet the statutory criteria described above. Issuers now offering these plans to beneficiaries entitled to Medicare due to disability or ESRD must make the same plans available to disabled or ESRD beneficiaries who meet the statutory criteria. Issuers not now selling to those under 65 are not required to start selling to those individuals. Finally, it is important to emphasize that the statute <u>mandates</u> that the premium charged in these circumstances must not be established in a way that discriminates based on health status.

In either of the above situations, the Medicare beneficiary must apply for the Medigap policy not later than 63 days after the date that HMO coverage terminates, unless your State law provides for a longer period. (The 63-day period will generally begin January 1, 1999, unless a beneficiary meets the criteria for re-enrolling in a previous Medigap policy. In that case, the 63-day period begins on the effective date of the individual's disenrollment.) However, most beneficiaries will prefer to apply before the beginning of this period. While issuers may not sell a policy with an effective date before a beneficiary's HMO coverage terminates, because that would be duplicate coverage, nothing in the law prevents an issuer from accepting applications in order to make the new coverage effective the day after the old coverage ends.

As with previous amendments to the Federal Medigap law, section 4031 of the BBA specifies that State law and regulations must comply with the requirements of section 1882 of the Social Security Act <u>and</u> with standards contained in the NAIC's Medicare Supplement Model Regulation. The Model Regulation, as revised to reflect the BBA amendments, tracks the statutory language of these protections. As you may be aware, HCFA has worked with the NAIC to correct an error in the drafting note that follows section 12.B(2) of the Model Regulation, and

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10/22/98 - a.m.

the NAIC issued a memorandum on October 16 explaining this change. A *Federal Register* notice, being published shortly, will transmit to the States the revised Model Regulation. This revised version is the Model Regulation that must be adopted by all States. (The error, regarding the significance of the statutory reference to the year 2002, does not in any way affect the rights of beneficiaries whose current section 1876 managed care plans are terminating. It only pertains to beneficiaries who may, in the future, be covered by a Medicare+Choice organization.)

There may be some confusion on the part of Medigap issuers regarding the effective date of the guaranteed issue requirements described above. These requirements were added to section 1882(s) of the Social Security Act by section 4031(a) of the BBA. Section 4031(d)(1) mandated a July 1, 1998 effective date. The confusion results from the fact that the statute incorporates two parallel enforcement mechanisms – one State and one Federal.

States clearly have the primary authority for enforcement of Medigap requirements under their approved regulatory programs. In order for your State to continue to have an approved regulatory program under section 1882(b) of the Social Security Act, State laws and regulations must conform to the new Federal requirements. If changes to your State laws and regulations are required in order for the State to enforce these provisions, section 4031(e) of the BBA deems your program to continue to be an approved program during a transition period of, in most cases, up to a year after the NAIC adopted its Model Regulation, which was April 29, 1998.

However, regardless of when the State laws and regulations come into conformity with the Federal requirements, it is essential for Medigap issuers to understand that the Federal guaranteed issue requirements added to section 1882(s) by the BBA, as well as the Federal civil money penalty enforcement authority in section 1882(s)(4), apply to all Medigap issuers as of the statutory effective date, July 1, 1998.

Finally, we are aware that some States have no approved policy forms for beneficiaries under 65 and that the NAIC Model Regulation specifies that issuers may not issue new policy forms without filing them for your approval. Approval of policy forms for beneficiaries under 65 who meet the specific statutory requirements is desirable if it can be done on an expedited basis. If this is not possible, however, we believe the guaranteed issue protections for these beneficiaries exist only for a policy "that is offered and is available for issuance to new enrollees by such issuer" (section 1882(s)(3)). We request that you make this clear to issuers in your State as quickly as possible.

The prohibition on discrimination in pricing also raises the issue of agent compensation. Some issuers have, in the past, attempted to circumvent statutory guaranteed issue requirements imposed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) by reducing or eliminating agent compensation for sales to individuals who meet the statutory requirements.

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If this were to happen, we assume that States would act as they did in the HIPAA context to address similar abuses.

HCFA's Outreach Campaign

Through our regional offices, HCFA has also initiated an outreach campaign to help Medicare beneficiaries understand their rights and options. This campaign will target those areas where Medicare beneficiaries are most affected by HMO withdrawals and inform them of their rights and options – both that they are automatically eligible for the Original Medicare Plan and what their Medigap rights and protections are. As part of this plan, HCFA is enlisting a large network of public and private partners who serve the Medicare population (including xxxxxxx) to provide their members with needed information through newsletters, conferences, and targeted information campaigns. As part of this campaign, you should be aware that beneficiaries who are denied access are being instructed to contact their State's insurance department. They are also instructed to contact HCFA's regional offices if they have difficulty resolving their individual concerns. In those States with significant plan withdrawals, staff from our regional offices will contact your office to identify ways that we can work together to ensure that the correct information is shared with beneficiaries. In addition, HCFA will post new information on the Medicare Internet site (www.medicare.gov), so that beneficiaries in every local area have the most up-to-date information on available HMO coverage options.

SENT BY:Xerox Telecopier 7020 ; 1-23-98 ; 2:46PM ; 3957289→ 65557;# 1

Date___________

FAX

Health Division

Office of Management and Budget
Executive Office of the President
Washington, D.C. 20503

To: Chris Jennings + Josh Gotbaum
Fax:
Phone:

From: Tim Hill/Yvette Shenouda

Number of Pages (not including cover):

Subject: Here is some background on the 10 f+A policies being announced today. Please call w/ questions

---

Please call if there are any problems with this transmission:

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Health & Human Services Unit	202/395-4925
Health Programs & Services Branch	202/395-4926
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Health Division (Room 7002)	202/395-5648

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Error Reduction: Base Medicare Payment for Drugs on Provider Acquisition Cost

Examiner: Yvette Shenouda

Proposal. Base Medicare's payment for drugs on the provider's actual acquisition cost of the drug.

5-Year Savings: ~~$300~~ 690 million

Background. While Medicare does not have an expansive outpatient drug benefit, it does cover certain kinds of outpatient drugs, e.g., specific drugs that are used with home infusion or inhalant equipment, and drugs that are prescribed for dialysis and organ transplant patients. Medicare typically pays for these drugs based on the charge submitted by providers, usually physicians or pharmacies. Information from the HHS/OIG and anecdotal sources suggest that Medicare currently pays 15 to 30 percent more than what the provider paid for the drug.[26]

Discussion. By basing Medicare's payment on the provider's acquisition cost of the drug, you eliminate the mark-up which providers place on drugs.

This proposal was included in the President's FY 1998 Budget. However, it was modified by the BBA such that the payment limit is now 95 percent of any wholesale price. CBO scored the President's proposal at $700 million and the BBA at $400 million over five years. The scoring difference reflects the fact that the average wholesale price is easily "gamed", while acquisition cost is a somewhat tighter payment limit.

Physician and pharmaceutical groups will be against this proposal because Medicare will be reimbursing them at a lower rate than it has in the past.

[26] "Appropriateness of Medicare Prescription Drug Allowances" HHS/OIG, May 1996.

(8)

Error Reduction: Reduce Medicare Epotein (EPO) Payments by ~~5~~ 10 Percent
Examiner: Tim Hill

Proposal. Reduce Medicare's reimbursement for EPO by 5 percent per dose, or ~~50 cents~~ $1.00

5-Year Savings: ~~$100 million~~ $320 MILLION

Background. EPO is a drug used to treat anemia related to chronic renal failure. It is a sole source drug, meaning that its manufacturer (Amgen) is competitively protected under the Orphan Drug Act. Medicare is the largest purchaser of EPO.

Medicare reimbursement for EPO totals nearly $1 billion per year. Prior to 1993, Medicare payment was $11.00 per dose. OBRA 1993 reduced Medicare's payment by $1.00 per dose based on an HHS IG report that concluded that dialysis facility costs for EPO – before manufacturer rebates – were approximately $10.00 per dose, $1.00 less than Medicare's $11.00 reimbursement rate. **The HHS IG report also concluded that some facilities received a 2 to 8 percent manufacturers rebate and that Medicare had no way to capture the savings from this rebate.**

Discussion. This policy would reduce Medicare's reimbursement for EPO by 5 percent per dose and would capture some of the savings from the manufacturers rebate. This policy could be implemented administratively. However, implementing the policy through regulation rather than through legislation means that there would be no scoreable savings associated with it. Dialysis facilities, ESRD-related beneficiary groups and the manufacturer of EPO are likely to object to this change.

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ANALYSIS:

Issue 1: How should a proposed increase in provider cost report audits and medical reviews be financed?

Background. In FY 1998, HCFA will spend $172 million on provider audits and $153 million on medical review funded through the Medicare Integrity Program discussed above.

Provider audits are a review of a sample of provider cost reports. Only those providers paid on a cost basis are audited. Providers paid on a cost basis include home health agencies, skilled nursing facilities and some hospitals. The cost reports are reviewed to insure that reported costs per unit are reasonable relative to Medicare's rules and that the amount that was actually paid for these services is consistent with the level of services provided. In 1997, HCFA performed about 90,000 provider audits, which resulted in adjustments (savings) of approximately $2 billion.[9]

Medical Review (MR) is the process of systematically and regularly analyzing claims data and prioritizing which claims will be examined to determine the reasonableness and necessity of the service or procedure. Medical review can be implemented on a prepayment basis, that is claims can be reviewed before they are paid to assess the medical necessity of certain procedures or visits. If the procedures are unnecessary, the claim is never paid. Medical reviews can also be implemented on a postpayment basis, that is claims can be reviewed after they are paid to assess the medical necessity of procedures or visits. HCFA encourages the prepayment medical reviews.

HCFA's Proposal. In FY 1999, HCFA proposes to double the number of audits and medical reviews over the FY 1998 level. This increase would be funded through a combination of user fees and scoring mechanisms.

First, HCFA plans to charge providers for Medicare's audit of their annual cost reports. The proposed fee would be equal to the full cost of provider audit activities, and act as a deterrent to inflating reported costs. HCFA anticipates collecting $395 million from this proposed audit user fee, which is $195 million above the current level of effort. Under HHS' FY 1999 budget proposal, these fees, which would first be collected through the mandatory Medicare Integrity Program spending account, would then be deposited to the discretionary HCFA program management account, not the HCFAC Program account. Once in the program management account HHS proposes to spend the collected fees on HCFA's salaries and expenses, claims processing, Medicare contractors and other administrative activities.

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[9] HD staff is attempting to verify this information.

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Second, HCFA requests an increase in mandatory spending of $395 million, $200 million for audits and $195 million for medical reviews. According to HCFA, this increase would allow them to increase the number of audits (from 90,000 in FY 1997 to 250,000 in FY1998) and medical reviews (from approximately 9% of all claims in FY1997 to approximately 18% of claims in FY 1998). Third, HCFA proposes that OMB agree to reinterpret the 1997 BBA scoring rule number 14 which states that, "no increase in receipts or decrease in direct spending will be scored as a result of provisions of a law that provides direct spending for administrative or program management activities". HCFA seeks to score $800 million in going back to the one-time scoring mechanism used in Kassebaum/Kennedy, $400 million of which would be used to finance the increase of audits by 190,000 and the increase of medical reviews by 9%, and $400 million of which would count as Medicare savings (see attached sheet for summary presentation of HCFA's proposal).

HCFA plans to charge providers a fee that will cover 100% of the cost of audits. The fee would vary by provider type and would be determined by projecting the amount to be spent on these activities for each provider type and then dividing that total by the number of providers of that type participating in the Medicare program. The fee would be withheld from payments made to each provider over the course of the year. HHS' budget submission did not outline an annual user fee schedule, however, HCFA recommends the following:

Hospitals	$23,000
Skilled Nursing Facilities	$8,000
Home Health Agencies	$11,500

HD Analysis. We have identified five concerns with the HHS proposal:

1) Dedication of fee to Program Management. HD staff believe that a user fee levied on the industry for the cost of audits should not be used for unspecified program management administrative expenses. The user fee should be used to increase the number of audits. While it is a mechanism which will be attractive to HHS (and other agencies), the industry will see this as a "tax", not as a fee. Others would see this as a gimmick to shift mandatory dollars to discretionary activities.

2) BBA Precludes Scoring Audit Savings as an Offset. The scoring mechanism proposed by HHS is no longer available. In changes to the budget process scoring rule #14 precludes scoring increases in spending on administrative activities as saving mandatory dollars. The inclusion of scoring rule #14 came in response to the one-time suspension of rules to score the Kassebaum/Kennedy bill in 1996. While HHS and other agencies may find this attractive, budget committees, CBO, and others will see this as a scoring gimmick.

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(5)

3) Precedent setting. Taken together, concerns one and two could raise criticism about: a) reallocating user fee revenues for activities wholly unrelated to the activity that they are levied for, b) shifting mandatory dollars to finance discretionary activities and c) circumventing scoring rules when convenient.

4) Fees are Not Tied to Percentage of Costs Claimed. HCFA's cost for conducting an audit varies by provider size as well as provider type. On average, it may cost more to audit hospitals than skilled nursing facilities but a large skilled nursing facility may cost more to audit than a very small hospital. For this reason, the amount of the user fee should be tied to the percentage of costs claimed by the provider rather than on provider type. This would account for the differences in size among providers.

5) Impact of providers "dropping out" of the system. We believe that HCFA has not properly estimated the revenues obtained from this user fee, and the overall cost of conducting the medical reviews and audits. In particular, we do not believe that HHS has properly taken into account the potential for proposed regulations that will impose additional standards on suppliers of durable medical equipment, home health agencies and laboratory services, to cause providers to drop out of the Medicare system. This dropping will affect the cost of audits and medical reviews, the anticipated revenue from the user fees, and possibly patient access and customer satisfaction, two of HCFA's performance goals. In the case of home health agencies, the recently enacted home health moratorium may also contribute to a decrease in providers.

6) Cost Shifting. Additionally, there exists a possibility of "cost-shifting" from the providers back to Medicare. Cost shifting could occur by providers reporting the cost of the audit on their cost report. HCFA has not resolved whether or not providers will be allowed to report the cost of audits on their cost reports (see attached sheet for a discussion of allowing providers to pass the cost of a user fee through to Medicare on their cost reports).

Recommendation. Having considered the HHS proposals, the Health Division agrees with the goal and recommends that HCFA double audits and medical reviews in the following manner:

- assess the user fee for provider audits, after considering the impacts of cost-shifting and providers dropping out, and use the revenue to fund fully the $195 million currently financed base audits and a increase in audit activity of $200 million;
- use the displaced $195 million base audit resources to finance an increase in medical reviews, also while considering the impact of provider dropping when estimating the amount of funding needed; and
- disallow providers from reporting the cost of the audit on their cost reports.

Error Reduction: Clarify Medicare's Partial Hospitalization Benefit

Examiner: Tim Hill

Proposal. Preclude providers from furnishing partial hospitalization services in a beneficiary's home or in an inpatient or nursing home and authorize the Secretary to establish a prospective payment system for partial hospitalization services.

5-Year Savings: $120 million

Background. Currently, Medicare covers partial hospitalization services connected with the treatment of mental illness. Partial hospitalization services are covered only if the individual otherwise would require inpatient psychiatric care. The course of treatment must be prescribed, supervised, and reviewed by a physician. The program must be hospital-based or hospital-affiliated and must be a distinct and organized intensive ambulatory treatment service offering less than 24-hour-daily care.

Partial hospitalization services include individual and group therapy sessions, occupational therapy, services of social workers, drugs and biologicals, family counseling and diagnostic services.

Discussion. This proposal would discourage development of partial hospitalization programs targeted to patients in their homes or in settings where there is a residential population, such as nursing facilities and assisted living facilities and create a more reasonable payment method for these services. The proposal addresses current problems whereby providers inappropriately deliver these services in group or nursing homes where patients live and add costs to their base that are specifically excluded from payment.

The partial hospitalization benefit was intended to be a less-costly alternative to inpatient psychiatric care, however, the current reasonable cost reimbursement methodology has resulted in excessive payment and inappropriate payment for items and services that are excluded from the definition of partial hospitalization services.

The proposal is based on anecdotal HCFA evidence, there have been no HHS IG or General Accounting Office reports on this issue.

HCFA-99/31
12/3/97

HEALTH CARE FINANCING ADMINISTRATION
FISCAL YEAR 1999 LEGISLATIVE PROPOSAL

Civil Monetary Penalties for False Certification

Impose Civil Monetary Penalties (CMPs) for False Certification of Eligibility to Receive Partial Hospitalization and Hospice Services.

Current Law: Under Section 1128(A), any person or organization is liable for civil money penalties for providing a medical or other item or service that was not provided as claimed; medical or other item or service that a person knows or should know is false or fraudulent; a medical or other item or service that was not provided by a licensed physician or was provided by a physician who is excluded from the Medicare or Medicaid program. This provision also parallels the authority created in HIPAA for false certification of home health services.

Proposal: Create a new civil money penalty for false certification of the need for partial hospitalization or hospice services when the provider knows or should know that the beneficiary does not meet such requirements. Partial hospitalization services are services such as group or occupational therapy prescribed by a physician and furnished by a hospital or community mental health center on an outpatient basis.

Rationale: This proposal would penalize physicians for inappropriate admissions to partial hospitalization programs when those services either are not needed or can be met through other more appropriate means. This proposal would provide a strong incentive for physicians to accurately certify their patients' need for partial hospitalization and hospice services.

Effect on Beneficiaries: This proposal would ensure continued proper use of partial hospitalization and hospice services for those beneficiaries who need of this level of services.

Cost: To be determined.

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HCFA-99/42
12/3/97

HEALTH CARE FINANCING ADMINISTRATION
FISCAL YEAR 1999 LEGISLATIVE PROPOSAL

Recovery in Bankruptcy Situations

Permit Medicare and Medicaid to Recover Overpayments and Penalties from Bankrupt Providers.

Current Law: Under Chapter 11 of the U.S. Code, individuals declaring bankruptcy gain a range of basic protections regarding recovery of their assets, thus prohibiting creditors from collecting from the debtor. The Medicare and Medicaid programs had priority in bankruptcy proceedings prior to enactment of the Bankruptcy Reform Act of 1978.

Proposal: Provide that:

- o the automatic stay of actions during the pendency of bankruptcy proceedings does not apply to actions by the Secretary or a State with respect to participation in Medicare or Medicaid, including actions relating to program exclusion, CMPs, recovery of overpayments, and denial of claims;
- o debts owed to the United States or a State for an overpayment (except for an overpayment to a beneficiary or a penalty, fine, or assessment under Medicare, Medicaid, or title XI) are not dischargeable in bankruptcy;
- o repayment to the United States or a State of a Medicare or Medicaid debt, or for penalties, fines, and assessments with respect to a debtor's participation in Medicare or Medicaid, are considered final and not preferential transfers under the Bankruptcy Code;
- o bankruptcy courts must use Medicare rules for determining whether claims by a debtor under the Medicare program are payable, and the allowable amounts of such claims;
- o the notice to creditors required under the Bankruptcy Code must be provided, in the case of Medicare debt, to the Secretary rather than a fiscal agent; and
- o a claim for payment under Medicare may not be considered a matured debt payable to the bankruptcy estate until allowed by the Secretary.

Rationale: This bankruptcy proposal would increase the ability of HCFA and the States to recover overpayments and fines from sanctioned health care providers. Current law is not uniformly applied, which allows some sanctioned providers to use the protections afforded by the Bankruptcy Code to avoid paying fines or returning overpayments. In practice, each court makes its own determinations. When a provider reorganizes or ends operation so that its assets are sold

to pay creditors, Medicare and Medicaid are not a priority. Instead, our programs are treated in the same way as all other creditors and rarely benefit in the ultimate distribution. Changing the Social Security Act would give Medicare and Medicaid priority in recovering assets.

Effect on Beneficiaries: This proposal would allow HCFA to recover more penalties and fines from fraudulent providers. The recovery of these funds would provide needed revenue, and discourage continued fraudulent activities by providers and allow for a more secure administration of the Medicare and Medicaid programs.

Cost: To be determined.

HCFA-99/39

HEALTH CARE FINANCING ADMINISTRATION
FISCAL YEAR 1999 LEGISLATIVE PROPOSAL

Extension of Subpoena and Injunction Authority

Extend the Subpoena and Injunction Authority.

Current Law: Under 1128A, the Secretary has the authority to issue civil monetary penalties (CMPs) against fraudulent claims and against excluded providers who continue to provide services. Inherent in this power is subpoena and injunctive authority.

Proposal: Extend the testimonial subpoena power and injunctive authority that the Secretary has for civil money penalties to other administrative sanctions such as exclusions against Federal health care program providers. This authority would expand the Secretary's power to require witnesses to appear and produce testimony related to Medicare fraud and abuse cases.

Rationale: These investigative tools are needed in the complex investigations of fraud, kickbacks and other prohibited activities. Restricting that power exclusively to situations involving CMPs limits the tools investigators have to fight fraud and abuse.

Effect on Beneficiaries: This proposal would help expose a wider range of potential fraud and abuse violations, thereby ensuring that more program dollars are going for the proper delivery of care.

Cost: To be determined.

HCFA-99/34

HEALTH CARE FINANCING ADMINISTRATION
FISCAL YEAR 1999 LEGISLATIVE PROPOSAL

Medicare Secondary Payer

Require Insurance Companies to Report Liability and No Fault Insurance Payments for Medicare Beneficiaries.

Current Law: Medicare is the secondary payer to no fault and liability insurance (e.g., auto liability insurance, and property owner's liability insurance). The law does not require insurance companies to notify HCFA, providers, or suppliers of payments to which Medicare should be the secondary payer. Nothing in the law permits HCFA to require that the insurance companies that make these payments notify HCFA, providers, or suppliers of services.

Proposal: Require insurance companies to report to Medicare liability and no fault insurance payments made to Medicare beneficiaries or to providers and suppliers for services rendered to Medicare beneficiaries within 30 days of making the payment and to advise the beneficiary and any legal representative that Medicare has been so advised. Impose CMPs of $10,000 per event for failure to do so.

Rationale: Currently the burden for determining if there is a primary payer other than Medicare rests largely upon the provider or supplier of the services. However, this method is unreliable since often the beneficiary files a claim for no fault or liability insurance at some point after having told the provider or supplier that they would not seek payment from no fault or liability insurance. This results in Medicare being billed and making conditional payment. When an insurance payment is made, the provider or supplier may not be advised and thus cannot notify Medicare so that Medicare can initiate recovery of its conditional payment to the provider or supplier. At this point, often years after the services are furnished, the provider or supplier has been paid and does not know of the primary coverage. Neither the beneficiary, the beneficiary's attorney, nor the insurance company making the liability or no fault payment is specifically required to advise Medicare of the availability of this payment, nor do any of these parties have an incentive to notify Medicare. Hence, if Medicare is never notified, Medicare cannot collect the payments due to the program.

This proposal would ensure that Medicare is notified of all cases in which these payments are made so that Medicare can ensure that appropriate recovery is initiated.

Effect on Beneficiaries: Beneficiaries who receive these insurance payments would be pursued by Medicare for recovery of the amounts that the law makes primary to Medicare. They would continue, however, to have the full range of appeal, compromise and waiver rights available to them in these cases.

Cost: To be determined. Medicare does not know the extent to which there are insurance payments that are primary to Medicare about which Medicare is never notified.

11

HCFA-99/35

HEALTH CARE FINANCING ADMINISTRATION
FISCAL YEAR 1999 LEGISLATIVE PROPOSAL

Data Match Responses

Hold Employers Accountable for Failure to Respond to IRS/SSA/HCFA Data Match Questionnaires.

Current Law: Current law imposes a civil money penalty on employers who either do not respond at all to a Data Match questionnaire or who delay excessively in responding only if the failure or delay is willful and repeated.

Proposal: Remove the requirement that the failure to respond be willful and repeated in order for the employer to be subject to the civil money penalty and increase the amount of the applicable civil money penalty from $1,000 per individual to $5,000 per individual.

Rationale: Current law is ineffective. Employers know that it is virtually impossible for the government to establish willfulness, and repeatedness is a vague concept with respect to an annual or biannual questionnaire. As a result, thousands of employers either ignore the questionnaire or delay responding until the time period for Medicare to recover mistaken primary payments from the employer's group health plan has expired. This proposal establishes an incentive for employers to comply promptly with the reporting requirement. This would enable Medicare to avoid mistaken primary payments and to recover mistaken primary payments previously made.

Effect on Beneficiaries: Beneficiaries generally have lower out-of-pocket expenses when MSP claims are properly coordinated. This proposal would result in more claims being properly coordinated.

Cost: To be determined.

Effective Date: Upon enactment.

HCFA-99/36

HEALTH CARE FINANCING ADMINISTRATION
FISCAL YEAR 1999 LEGISLATIVE PROPOSAL

Insurer Reporting

Require All Group Health Plans to Report Information to Medicare.

Current Law: Group Health Plans are required to be primary payers to Medicare for services provided to aged and disabled Medicare beneficiaries who have group health plan coverage based on their own or a spouse's current employment and for services provided to those newly entitled to Medicare because of end stage renal disease for a 30-month coordination period. There is no statutory requirement for group health plans to report to Medicare the identities of those beneficiaries for whom they are responsible for primary coverage.

Proposal: Require all group health plans to provide information to Medicare that is necessary to enable Medicare to identify beneficiaries for whom specific group health plans are the primary payer.

Rationale: This proposal would ensure that Medicare is paying the appropriate amount for beneficiaries who may be covered by group health plans. The problem of Medicare's initially paying and then attempting to recover payment (or not having enough time to recover payment) from a group health plan could largely be eliminated by requiring all group health plans to report information about the insurance coverage of Medicare beneficiaries. HCFA would then know up-front whether Medicare was responsible for primary payment or whether Medicare only was responsible for a secondary payment. The appropriate payments could be made in a timely fashion and resources would not be spent in attempting to recoup mistaken payments that may not be recoverable for a variety of reasons (e.g., a plan's timely filing requirement).

Effect on Beneficiaries: Beneficiary out-of-pocket expenses would be reduced when Medicare is the secondary payer when claims are initially submitted correctly.

Cost: This proposal was scored at $814 million in savings over 5 years as part of the Administration's fraud bill. However, in FY 96 alone, an estimated $400 million was saved by collecting this information from the Blues and Travelers Insurance, as the result of a settlement agreement. Revised/updated savings estimates could exceed $3 billion over 5 years.

Effective Date: Upon enactment.

HCFA-99/37

HEALTH CARE FINANCING ADMINISTRATION
FISCAL YEAR 1999 LEGISLATIVE PROPOSAL

Set Conditions for Double Damages

Impose Double Damages When a Third-party Payer Fails to Acknowledge its Status as Primary Payer.

Current Law: Section 1862 (b)(2) of the Social Security Act permits the government to take legal action to recover mistaken Medicare primary payments from third-party payers that have failed to comply with the Medicare secondary payer provisions and may collect double damages.

Proposal: Ensure that double damages would be imposed in cases where a third-party payer has failed to acknowledge its status as primary payer, unless the third-party payer can demonstrate that it did not know, and could not have known, of its responsibility as the primary payer.

Rationale: This proposal would reduce gaming of the system by third-party payers by imposing a stiff damage penalty for failure to comply with current statutory requirements.

Effect on Beneficiaries: Beneficiary out-of-pocket expenses would be reduced when Medicare is the secondary payer if claims are initially submitted correctly.

Cost: To be determined.

Effective Date: Upon enactment.

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Provider Savings: Pay Certain Medicare Providers Competitively

Examiner: Jonathan Blum

Proposal. Expand the current HCFA Centers of Excellence demonstration which enables Medicare to cap payments for certain routine surgical procedures through a competitive bidding process with providers. The demonstration would be expanded from 10 states to include all urban areas.

5-Year Savings: $240 million

Background. Currently, HCFA is conducting a demonstration that will pay facilities in 10 states, considered to be "centers of excellence," a capped payment for coronary artery bypass graft (CABG) surgery or other heart procedures, knee surgery, hip replacement surgery, and other procedures that the HHS Secretary determines to be appropriate. Providers will negotiate with HCFA a flat payment to cover all of costs (hospital and physician) associated with the procedures. HCFA expects up to 100 total facilities to participate in the current demonstration. This demonstration developed from a smaller HCFA demonstration during the early 1990s of seven sites that performed CABG and cataract surgery. An independent evaluation determined that, on average, the flat payment mechanism resulted in reduced costs to the Medicare program without any change in health status of patients who received care from these centers. The Administration and the House supported expanding the demonstration in the Balanced Budget Act of 1997 (BBA 97); however, the provision was dropped from the Conference Agreement.

Discussion. Even though the Medicare program is the largest purchaser of medical care in the US, it does not receive volume discounts like other large purchasers. At the same time, hospitals may not have enough patients to become more proficient providers of care and thus be able to offer discounts to the Medicare program. **The Centers of Excellence demonstration is intended to enable the Medicare program to receive volume discounts on routine surgical procedures and, in return, enable hospitals to increase their market share and gain clinical expertise.** In effect, participants in the demonstration will receive a fixed payment for all hospital and physician services that is lower than the average total payment to non-participants. Facilities currently receive a fixed payment for the operating and capital portions of inpatient care; however, physician and other clinical services remain uncapped. The demonstration will enable Medicare to cap all related services.

The Administration supported expanding the demonstration during the BBA 97 and the House bill included the expansion, although it was ultimately dropped from the Conference Agreement. However, expanding the demonstration may incur resistance from some providers. Even though the demonstration does not require patients to receive care at participating facilities, expanding it may further

split the market for these procedures. Providers who are not likely to be selected to participate would argue that they would lose market share if the demonstration were expanded.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

Press Office
Washington, DC 20201

December 2, 1998

HCFA Press Office
(202) 690-6145

STATEMENT OF NANCY-ANN DePARLE
ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

We agree with the Inspector General's recommendations to strengthen the fraud-fighting efforts of the private contractors who process and pay claims. For several years, we've pressed our contractors to do more, and we've asked Congress repeatedly for more leverage over them.

This Administration has asked Congress five times to enact contractor-reform legislation that will give us more leverage over those who don't do their work right and replace them with other companies, when appropriate. To date, Congress has not acted on this legislation.

I also established a new position to oversee contractors' work and hired a physician with experience in our anti-fraud efforts and expertise in the work done by contractors to lead our efforts.

In 1997, we required contractors to use a standard computer system to identify fraud proactively and prevent losses.

In September, we requested proposals to hire new special fraud-fighting contractors to enhance our efforts. We expect to hire contractors to do this additional work in 1999.

And this fiscal year, our regular contractors will attend the Inspector General's training sessions to further educate them about developing and referring fraud cases.

Medicare's fight to eliminate waste, fraud and abuse involves many fronts and many partners, including the Inspector General, the Department of Justice, state and local agencies and our contractors.

Last year, these combined efforts saved Medicare $7.5 billion and returned another $1 billion to the Medicare Trust Fund. We know that we must do more, and we will continue to demand that our private contractors do their part.

# # #

USA Today article on HHS Inspector General's report on Fiscal Intermediary Fraud Units
December 2, 1998
DRAFT – December 2, 1998
For Internal Use Only

BACKGROUND: USA Today ran a story today about an HHS Inspector General's report on the fraud units of Medicare's fiscal intermediaries, the private contractors who process and pay Medicare claims. Based on mostly 1996 data, the report found some contractors do little to identify potential fraud on their own, as they are expected to do. HCFA has worked to improve their efforts in recent years and to gain greater flexibility to hire new and different contractors.

Q: USA Today writes that Medicare's contractors aren't doing enough to fight fraud. Why hasn't the Administration done more to make sure they spot and stop fraud?

A: This Administration has done more to fight waste, fraud and abuse in the Medicare program than any previous Administration. In fact, our efforts saved Medicare $7.5 billion and returned another $1 billion to the Medicare Trust Fund last year alone. Our efforts involves many fronts and many partners, including HCFA, the Inspector General, the Department of Justice, state and local authorities, and private businesses.

We agree that we need to strengthen the fraud-fighting efforts of Medicare's fiscal intermediaries, the private contractors who process and pay claims. In fact, we began to take such steps well over a year ago.

Five times, this Administration has asked Congress to enact legislation that will give Medicare more leverage over those who don't do their work right and replace them with other companies, when appropriate. To date, Congress has not acted on this legislation.

In 1997, Medicare required fiscal intermediaries to use a standard computer system to identify fraud proactively and to prevent losses. These private companies participated in a fraud-fighting conference in March and attend sessions regularly to tackle these issues. This year, the Inspector General will provide additional training on developing cases and referring them to law enforcement.

Date: Wednesday, June 3, 1998
FACT SHEET
Contact: HHS Press Office (202) 690-6343

THE CLINTON ADMINISTRATION'S COMPREHENSIVE STRATEGY TO FIGHT HEALTH CARE FRAUD, WASTE AND ABUSE

__Overview:__ Since 1993, the Clinton Administration has focused unprecedented attention on the fight against fraud, abuse and waste in the Medicare and Medicaid programs. Today, the result is a series of investigations, indictments and convictions, as well as new management tools to identify wasteful mispayments to health care providers.

The heightened focus on fraud and abuse since 1993 by the HHS Inspector General, the FBI and Department of Justice, HHS' Health Care Financing Administration (HCFA) and others throughout government is yielding a new, more detailed picture of fraudulent activities aimed at the Medicare and Medicaid systems. New surveys and audits have helped investigators pinpoint areas of vulnerability and ongoing patterns of abuse, which in turn are leading to changes in law enforcement and administrative actions.

At HHS, Secretary Shalala launched Operation Restore Trust, a ground-breaking project aimed at coordinating federal, state, local and private resources and targeting them on areas most plagued by abuse. During its two-year demonstration phase, the project identified $23 in overpayments for every $1 of project costs. In addition, the Secretary led the way toward steady, guaranteed funding for anti-fraud efforts by the HHS Inspector General, included in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

On January 26, 1998, President Clinton sent to Congress the first annual report of the Health Care Fraud and Abuse Control Program -- created by HIPAA -- which shows remarkable progress in rooting out health care fraud and abuse. In FY 1997 alone -- the first full year of anti-fraud and abuse funding under HIPAA -- nearly $1 billion was returned to the Medicare Trust Fund, the largest amount ever. HHS also excluded more than 2,700 individuals and entities from doing business with Medicare, Medicaid, and other federal and state health care programs in FY 1997 for engaging in fraud or other professional misconduct – a near doubling (a 93 percent increase) over 1996. In addition, HHS increased convictions for health care fraud-related crimes by nearly 20 percent, and pursued 4,010 civil health care fraud cases -- an increase of 61 percent over 1996. Since 1993, actions affecting HHS programs alone have saved taxpayers more than $20 billion and increased health care fraud convictions by more than 240 percent.

The Administration will continue to expand its efforts to identify wrongdoers and to obtain convictions. The budget bill signed by President Clinton in August 1997 includes many new fraud fighting tools sought by the Administration. In addition, President Clinton proposed an anti-fraud and abuse legislative package as part of his FY 1999 budget that would save Medicare some $2 billion over 5 years.

CLINTON ADMINISTRATION EFFORTS TO FIGHT FRAUD, WASTE, AND ABUSE

Operation Restore Trust. In May 1995, President Clinton launched Operation Restore Trust (ORT), a comprehensive anti-fraud initiative in five key states designed to test the success of several innovations in fighting fraud and abuse in the Medicare and Medicaid programs. HCFA, the HHS Inspector General, and the HHS Administration on Aging are working in partnership to carry out ORT. During the two year demonstration, ORT identified $23 in overpayments for every $1 spent looking at the fastest-growing areas of Medicare, including home health care, skilled nursing facilities, and providers of durable medical equipment. In May 1997, Secretary Shalala announced a new, nationwide expansion of ORT to look at additional areas of fraud and abuse this year.

- Fraud and Abuse Hotline. HHS has expanded the 1-800-HHS-TIPS hotline started in 1995 to report fraud and abuse in Medicare and Medicaid programs. Over 38,000 complaints that warranted follow-up action have been received since it began service. The hotline is staffed Monday through Friday, 8:30 a.m. to 6:00 p.m. Eastern Time, and assistance is available in both English and Spanish. Medicare beneficiaries across the nation are now receiving the toll-free number on their monthly Medicare statements, making it easier for them to help Medicare crack down on fraud and abuse.

- Administration on Aging Ombudsman Program. As a partner in Operation Restore Trust, the Administration on Aging has trained thousands of paid and volunteer long term care ombudsman and other aging services providers to recognize and report fraud and abuse in nursing homes and other long term care settings.

Guaranteed and Expanded Funding. In August 1996, President Clinton signed the Health Insurance Portability and Accountability Act (HIPAA) legislation into law, which for the first time created a stable source of funding for fraud control. This law established the Health Care Fraud and Abuse Control Account, a key proposal of the Clinton Administration, to which money is deposited annually from the Medicare Part A Trust Fund to help finance expanded fraud and abuse control activities. The additional funding, $104 million in FY 1997 and up to almost $120 million in FY 1998, is divided between HHS and the Department of Justice to coordinate federal, state and local health care law enforcement programs; conduct investigations, audits, evaluations and inspections relating to the delivery and payment of health care; help facilitate enforcement of civil, criminal and administrative statutes on health care fraud and abuse; provide guidance to the health care industry on fraudulent health care practices; and establish a national data bank to receive and report final adverse actions against health care providers.

- New Anti-Fraud Grants. On August 21, 1997, HHS awarded more than $2.25 million in grants funded by HIPAA for new programs to aid in the fight against health care fraud and abuse. Of this amount, more than $1.5 million in "Health Care Fraud and Abuse Control Grants" will be administered by HCFA, the HHS Inspector General, and the Department of Justice. The HHS Administration on Aging also announced a total of $900,000 in grants to be administered through state offices on aging, which will help expand the Department's highly successful Operation Restore Trust program. In June 1997, the Administration on Aging also awarded funds to 12 local agencies to recruit and train retired professionals to teach older persons and their families what to look for when reviewing their billing statements and how to report potential waste, fraud, and abuse.

- Expanded Office of the Inspector General (OIG). In FY 1997, the Office of the Inspector General received approximately $70 million from the Health Care Fraud and Abuse Control Account. The

funding enabled the OIG to open six new field offices to facilitate enforcement actions, increasing from 26 to 31 the number of states in which the OIG is present. Provisions under HIPAA will also establish a fraud and abuse database to identify health care providers who have been the subject of adverse actions as the result of illegal or abusive practices and award grants to partner agencies engaged in investigations, prosecutions and audits of health care fraud and abuse.

- Increased Efforts by the Department of Justice (DOJ). The Department of Justice was allocated approximately $24 million of the money appropriated from the Health Care Fraud and Abuse Control Act to step-up their efforts to investigate fraud and abuse and enforce criminal and civil statutes applicable to health care fraud and abuse. In the last four years the Department of Justice has increased resources, focused investigative strategies, and improved coordination among law enforcement to fight health care fraud. Due to DOJ's comprehensive efforts, the number of health care fraud convictions increased by more than 240 percent since FY 1992.

- Incentive Program for Fraud and Abuse Information. On June 3, 1998, HHS announced a new regulation to implement the Incentive Program for Fraud and Abuse Information, created in the Health Insurance Portability and Accountability Act. Under this program, which starts in January 1999, rewards will be paid to Medicare beneficiaries and others who report fraud and abuse in the Medicare program if their information leads directly to the recovery of Medicare money for fraudulent activity not already under investigation by law enforcement agencies, the HHS Inspector General, state agencies or Medicare's contractors. Rewards will be for 10 percent of the recovered overpayment or a $1,000 maximum, and will be financed from the collected overpayments, after all other fines and penalties have been recovered.

Tightening Standards for Home Health Care Providers. HHS declared a moratorium on enrollment of new home health providers in the Medicare program while implementing new regulations to prevent fraud in home health care. The new regulations include provisions to: (1) require home health agencies to post surety bonds of at least $50,000 before they can enroll or re-enroll in Medicare; (2) require a minimum number of patients to establish an agency's experience in the industry prior to seeking Medicare enrollment; and (3) require agencies to submit detailed information about all businesses they own to prevent the use of shady financial transactions to exploit Medicare. This action is consistent with strong evidence that the best way to stop fraud and abuse in our Medicare program is to prevent unscrupulous providers from ever entering the program. The moratorium was lifted on January 14, 1998. HHS is also developing a new renewal process for home health agencies currently in the program, and is doubling audits and increasing claims reviews to help weed out bad apple providers. In addition, the Clinton Administration in March 1997 proposed a new regulation that would revise the federal standards (Condition of Participation) that home health agencies must meet in order to participate in the Medicare program. The new rules require home health agencies to be more accountable for the care they provide and to conduct criminal background checks on the aides they hire.

At the Clinton Administration's urging, several measures to fight fraud in home health care were included in the Balanced Budget Act of 1997, including:

- Establishing a prospective payment system for home health services, to be implemented by Oct. 1, 1999. Moving to a PPS system will be a tremendous tool to stem the flow of home health care dollars. HCFA will set, in advance, what it will pay for a unit of service, how many visits will be included in that unit and what mix of services will be provided.

- Paying home health services based upon the location where the service is provided-the patient's home-as opposed to where the service is billed. This will stop agencies from getting higher urban

reimbursement when, in fact, the service occurred in a lower-cost rural setting.

- Eliminating periodic interim payments to home health agencies. These payments were previously used to encourage Medicare participation and now are no longer necessary.
- Tightening eligibility for home health services so that providers can no longer game the system by certifying patient eligible for home health services simply because they need blood drawn on a regular basis. There is a separate benefit for blood drawing services only.

New Requirements for Durable Medical Equipment Suppliers. On January 20, 1998, HHS published a regulation to help prevent fraud and abuse in the supply of durable medical equipment (DME) for Medicare beneficiaries. DME has been identified as a prime area for potential fraud against Medicare, and it is one of the special focuses of HHS' anti-fraud initiative, Operation Restore Trust. Under the regulation, suppliers of DME, including wheelchairs, canes, and other medical supplies, would be required to obtain surety bonds of at least $50,000. The requirement applies to payment for any DME furnished on or after January 1, 1998. In addition, the proposed regulation would ban DME supplier telemarketing; require suppliers to have a physical office and a listed phone number; codify a requirement that suppliers reenroll in Medicare every three years; prohibit suppliers from reassigning a supplier number; and apply criminal and civil sanctions for misrepresentations on billing number applications. On January 24, 1998, the President announced that, to ensure that medical equipment suppliers are providing the medical devices they claim, the Department of Health and Human Services will conduct nationwide on-site inspections of medical equipment suppliers.

The Medical Integrity Program (MIP) and Payment Safeguards. This system of payment safeguards, also authorized by HIPAA, identifies and investigates suspicious claims throughout Medicare, and ensures that Medicare does not pay claims other insurers should pay. MIP also ensures that Medicare only pays for covered services that are reasonable and medically necessary. HCFA's current payment safeguards are already paying dividends in cost savings. These safeguards comprise a comprehensive system which attempts to identify improper claims before they are paid, to prevent the need to "pay and chase." HCFA's current strategy for program integrity focuses on prevention and early detection. Some of the payment safeguard activities include: the Medicare Secondary Payer Program, medical review, cost report audits and anti-fraud activities. The payment safeguard activities returned $14 for every $1 spent, and saved an estimated $7.5 billion for FY 1997. The Secondary Payment Program alone, which is identifying whether insurers should pay claims that in the past have inappropriately been paid by Medicare, saved more than $1.1 billion in 1997.

Improving Health Care Industry Compliance. The HHS Office of the Inspector General has issued compliance program guidance for hospitals to assist in developing measures to combat fraud and abuse in the hospital industry. In addition, the OIG released guidelines identifying steps the clinical laboratory industry should undertake to improve adherence to Medicare and Medicaid statutes, regulations, and program directives. The guidelines are part of the Inspector General's continuing efforts to work with health care providers to promote voluntary compliance with the applicable statutes, regulations, and program requirements pertaining to federal and other health care programs. In addition, the OIG has issued fraud alerts, advisory opinions and other guidance as part of an ongoing effort to promote the highest level of ethical and lawful conduct by the health care industry.

Correct Coding Initiative. In 1994, HCFA began the Correct Coding Initiative by awarding a contract for the development of correct coding policy for all physician billing codes referred to as current procedural terminology (CPT) codes. Implemented in 1996, this enhanced pre-payment, control and associated software update resulted in a projected $260 million in savings in FY 1997. In FY 1998,

HCFA will continue to develop coding policy and edits with a focus on new CPT codes with the potential for high utilization.

Substantive Claims Testing. HCFA is now working to develop a substantive testing process to help determine not only whether claims are paid properly, but also whether services are actually rendered and medically necessary.

Education Efforts. HCFA's contractors educate the provider billing community, including hospitals, physicians, home health agencies and laboratories about Medicare payment rules and fraudulent activity. This education covers current payment policy, documentation, requirements and coding changes through quarterly bulletins, fraud alerts, seminars and, more importantly, through local medical review policy.

Los Alamos National Laboratory. The lab is developing sophisticated pattern detection methods for application to Medicare's vast data banks. These methods will help identify and target suspect claims which need additional review. This effort could start directing investigators to new cases of fraud and abuse.

Tough New Requirements for Medicare and Medicaid Participants. President Clinton's FY 1998 budget proposal included several additional anti-fraud provisions. In addition, President Clinton introduced new legislation in March 1997, the "Medicare/Medicaid Anti-Waste, Fraud and Abuse Act of 1997," that established tough new requirements for individuals and companies that wish to participate in Medicare and Medicaid. Most of the Clinton Administration's recommendations were included in the budget bill signed by the President on August 5, 1997, including:

- Penalties for services billed by a provider who has been excluded by Medicare and Medicaid.
- Penalties for hospitals who contract with providers who have been excluded by Medicare and Medicaid.
- Civil monetary penalties levied on providers that violated the anti-kickback statute, under which the physician received some kind of incentive for referring patients.
- Requiring health care providers applying to participate in Medicare or Medicaid to provide their Social Security numbers and their employer identification numbers so HCFA can check an applicant's history for past fraudulent activity.
- Barring convicted felons from participating in Medicare and Medicaid.

10-Step Anti-Fraud and Abuse Legislative Package. To build on the Administration's unprecedented success in fighting health care fraud, waste, and abuse, President Clinton's FY 1999 budget proposal includes an anti-fraud and abuse legislative package that saves Medicare some $2 billion over five years. The package includes measures that would:

Note longer version attached

- Eliminate excessive payments for certain drugs, for which the Inspector General has reported Medicare currently overpays;
- Ensure Medicare does not pay for claims that ought to be paid by private insurers, such as taking steps to ensure that Medicare is aware of liability settlements and of other coverage obligations of private insurers;

- Ask providers to pay for their audits, which will allow Medicare to double the number of audits; and
- Ensure that filing for bankruptcy cannot shield providers from their obligations to Medicare.

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PRESIDENT UNVEILS TEN LEGISLATIVE PROPOSALS AS PART OF HIS ONGOING ANTI-FRAUD, WASTE, AND ABUSE COMMITMENT
January 23, 1998

(1) **Eliminating Wasteful Excessive Medicare Reimbursement for Drugs.** A recent report by the HHS Inspector General found that Medicare currently pays hundreds of millions of dollars more for 22 of the most common and costly drugs than would be paid if market prices were used. For more than one-third of these drugs, Medicare paid more than double the actual average wholesale prices, and in one case pays as high as ten times the amount. This proposal would ensure that Medicare payments be reduced to the actual amount that the drugs cost.

O/d

(2) **Eliminating Overpayments for Epogen.** In a 1997 report, the HHS Office of Inspector General (OIG) found that reducing the Medicare reimbursement for Epogen (a drug used for kidney dialysis patients) to reflect current market prices would result in more than $100 million in savings to the Medicare program and beneficiaries.

(3) **Doubling the Number of Audits to Ensure That Medicare Only Reimburses for Appropriate Provider Costs.** Right now, not all cost-based providers (e.g., hospitals, home health, non-PPS, skilled nursing facilities) are audited. This proposal would assess a fee to cover all audits and cost settlement activities for health care providers. These steps help ensure that Medicare only makes payments for appropriate provider costs.

(4) **Lowering Medicare's Payments for Equipment Through A Nationwide Competitive Pricing Program.** Competitive Pricing would let Medicare do what most private and other government health care purchasers do to control cost -- lower costs by injecting competition into the pricing for equipment and non-physician services.

O/d

(5) **Eliminating Abuse of Medicare's Outpatient Mental Health Benefits.** The HHS Inspector General has found abuses in Medicare's outpatient mental health benefit -- in particular that Medicare is sometimes billed for services in inpatient hospitals or homes. This proposal would eliminate this abuse by requiring that these services are only provided in the appropriate treatment setting.

(6) **Creating Civil Monetary Penalties For False Certification of The Need For Care.** Recent HHS Inspector General reports identified providers who inappropriately certified that beneficiaries needed out-patient mental health benefits and hospice services. This proposal would impose penalties on physicians who falsely certify their patients' need for these two benefits.

6/d

(7) **Preventing Providers From Taking Advantage of Medicare By Declaring Bankruptcy.** Providers who have defrauded and abused Medicare often file for bankruptcy in order to avoid paying fines or returning overpayments, leaving Medicare strapped with the bills. This proposal would give Medicare priority over others when a provider files bankruptcy.

(8) **Taking Action To End Illegal Provider "Kickback" Schemes.** A serious area of fraud is "kickback" schemes, where health care providers unnecessarily send patients for tests or to facilities where the provider is financially rewarded. While we have established criminal penalties for these schemes, additional tools are needed to stamp out this practice: specifically, allowing prosecutors to get a court order put an immediate halt to such schemes, and to allow civil as well as criminal remedies.

(9) **Ensuring Medicare Does Not Pay For Claims Owed By Private Insurers.** Too often, Medicare pays claims that are owed by private insurers because Medicare has no way of knowing the private insurer is the primary payer. These proposals would take steps to address these problems including: requiring insurers to report any Medicare beneficiaries they cover; allowing Medicare to recoup double the amount owed by insurers who purposely let Medicare pay claims the group plan should have made; and imposing fines for not reporting no-fault or liability settlements for which Medicare should have been reimbursed.

(10) **Enable Medicare to Capitate Payments for Certain Routine Surgical Procedures Through a Competitive Pricing Process With Providers.** This will expand HCFA's current "Centers of Excellence" demonstration to enable Medicare to receive volume discounts on these surgical procedures and, in return, enable hospitals to increase their market share and gain clinical expertise.