



FAX Transmission

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DATE: 12/1

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TOTAL NUMBER OF PAGES TRANSMITTED: 3

COMMENTS:

FYI - final press release.

OIG NEWS RELEASE

For Immediate Release - November 30, 1998

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Hospitals To Be Issued Patient Dumping Guidelines for HMO Enrollees

In a move to protect managed care plan enrollees who may be vulnerable to patient dumping abuses, the Office of Inspector General (OIG) and Health Care Financing Administration (HCFA) of the Department of Health and Human Services are issuing this week a proposed Special Advisory Bulletin alerting hospitals and doctors to their legal obligations to provide emergency medical care to plan members.

The proposed guidance will explain the Federal law prohibiting the denial of emergency care to patients, and will detail the government's position as to how the law applies to enrollees in health maintenance organizations (HMO) and other types of managed care plans. Additionally, it will suggest "best practices" on how to ensure compliance with the law. The notice is to be published in the *Federal Register* within the next two weeks. The public will be given 30 days from the date of publication to comment on the proposed guidance, after which a final Special Advisory Bulletin on the issue will be published in the *Federal Register*.

"This proposed guidance will make clear that despite the terms of any managed care agreements between plans, hospitals, and enrollees, Federal law requires that stabilizing medical treatment be provided in an emergency," Inspector General June Gibbs Brown stated in announcing the proposed bulletin. "No managed care plan or agreement, even if the agreement contains a prior authorization requirement, can excuse a hospital from providing needed emergency medical screening and stabilizing care to an enrollee in a managed care plan."

"Anyone who believes they are experiencing a medical emergency--regardless of their ability to pay or the kind of insurance they have--has a right to expect that hospitals and physicians will meet their obligations under Federal law to provide a required emergency medical screening and stabilizing care," HCFA Administrator Nancy-Ann DeParle said. "We will be vigilant in ensuring that hospitals and physicians fulfill their obligations."

The OIG and HCFA were prompted to develop the patient anti-dumping statute guidance partly in response to inquiries from the medical community for clarification of the law and partly in response to complaints that some managed care patients have been improperly denied emergency care.

The Federal Patient Anti-Dumping Statute provides that a patient who seeks emergency care at a Medicare-participating hospital must receive an appropriate medical screening examination. Treatment must be provided if an emergency medical condition exists, and the condition must be stabilized before the patient is discharged. A medically unstable patient may be transferred to another hospital if a doctor certifies that it is in the best interests of the patient or if an informed patient requests a transfer. Furthermore, a hospital is not permitted to delay the provision of an appropriate medical screening examination or further stabilizing treatment in order to inquire about an individual's method of payment, insurance status, or prior authorization.

investigations of patient dumping allegations have persuaded us that managed care patients may more likely be victims of dumping than other patients," Inspector General Brown said. "This situation is largely the result of some managed care plans requiring that enrollees and hospitals obtain prior authorization for certain medical services, including emergency room services. While hospitals sometimes feel caught between the obligations imposed under the statute and the expectations of managed care plans, they clearly must abide by the statute in these cases."

Violators of the anti-dumping statute face significant penalties. Large hospitals and doctors who negligently violate any requirements of the statute are subject to a civil money penalty of up to \$50,000 for each offense. The penalty for hospitals with fewer than 100 beds is \$25,000 per incident. Doctors found responsible for repeated or gross or flagrant violations can be excluded from participation in all Federal health care programs.

Publication of the proposed Special Advisory Bulletin signals an increased determination on the part of the Department of Health and Human Services to prevent patient dumping abuses. Over the past year, both the OIG and HCFA have significantly increased their caseloads and have beefed up their respective staffs assigned to investigating alleged dumping violations. During the recently ended 1998 fiscal year, the OIG settled 54 dumping cases that resulted in the imposition of \$1.8 million in penalties. In addition, OIG filed formal administrative action against three individual physicians and a hospital with respect to patient dumping violations. Three of these cases are being appealed. A fourth case still in adjudication involves a West Virginia doctor who was penalized \$100,000 by an administrative law judge for dumping two patients. That action, affirmed by the Departmental Appeals Board, is on appeal to the Court of Appeals for the Sixth Circuit.

COMPREHENSIVE PLAN FOR PROGRAM INTEGRITY



Health Care Financing Administration
Department of Health and Human Services
July 1998

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Comprehensive Plan for Program Integrity Executive Summary

As one part of our ongoing program integrity efforts, the Health Care Financing Administration (HCFA) sponsored a national conference on fraud, waste, and abuse in March 1998. This event brought together individuals from across industries and sectors, including key members of Congress, health care providers, representatives from the insurance industry, other private industries, and other government agencies, to talk about best practices and new strategies for confronting fraud and abuse. Many constructive lessons for fighting fraud and abuse resulted from the conference, many of which HCFA incorporates into its program integrity efforts.

To further our commitment to promoting the integrity of our programs, we are now leveraging the lessons learned from the March conference with our many existing Agency-wide program integrity activities. Through this marriage of existing activities and new ideas we have created a deliberate Comprehensive Plan outlining HCFA's overall program integrity strategy.

The following working draft of the Comprehensive Plan outlines HCFA's overall program integrity strategy. This plan includes:

- The Agency's program integrity goals;
- A brief description of current and ongoing program integrity activities;
- Key short-term initiatives for development and implementation; and
- A discussion about the resources necessary for HCFA to implement its program integrity strategy, including funding and technology.

The short-term initiatives include specific proposals to improve HCFA's management of program integrity activities, as well as proposals to address service specific program vulnerabilities. Our priorities are to:

- Increase the effectiveness of medical review and benefit integrity activities;
- Implement the Medicare Integrity Program;
- Implement payment safeguards for Balanced Budget Act provisions;
- Promote provider integrity;
- Initiate Millennium contingency planning; and,
- Address vulnerabilities in inpatient hospital care, congregational care, and managed care.

We are sharing this plan with our internal and external partners and welcome your comments so that this plan is viable, effective, and developed in a collaborative spirit. We intend to finalize the plan and submit it to Congress with the Fiscal Year (FY) 2000 Budget (subject to review by the Office of Management and Budget).

Comprehensive Plan Background

In the 1990s, HCFA has made tremendous progress in protecting the fiscal integrity of the Medicare and Medicaid programs. Program integrity efforts permeate every corner of HCFA, require the Agency to work in close collaboration with many partners, and are vital elements of every policy decision.

An example of our recent program integrity efforts is the partnership with enforcement agencies targeting fraud and abuse in the five States that account for nearly 40 percent of all Medicare and Medicaid beneficiaries. This two-year project, Operation Restore Trust (ORT), encompassed a wide range of projects aimed at eliminating fraud schemes and identifying vulnerabilities in the Medicare programs. Further, the Balanced Budget Act (BBA) of 1997 and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 provide significant new tools to assist us in facing the challenges that lie ahead.

In addition, HCFA's National Medicaid Fraud and Abuse Initiative directed by our Southern Consortium, has issued a report under separate cover which has served as a model for this Comprehensive Plan. While this plan includes many of the Southern Consortium's proposals, the National Medicaid Fraud and Abuse Initiative report may be a useful document for those readers who wish to explore HCFA's Medicaid program integrity efforts in greater detail.

As part of this Administration's ongoing efforts to root out fraud and abuse in the Medicare program, the President has proposed the six following Medicare and Medicaid anti-fraud, waste and abuse legislative initiatives.

- **Eliminating Excessive Medicare Reimbursement for Drugs.** This proposal would ensure that Medicare payments reflect provider's actual acquisition cost of the drugs without mark-ups.
- **Eliminating Overpayments for Epogen.** An Office of Inspector General (OIG) report found that Medicare overpays for Epogen, a drug used for kidney dialysis patients. This policy would change Medicare reimbursement to reflect current market prices.
- **Eliminating Abuse of Medicare's Outpatient Mental Health Benefits.** This proposal would eliminate abuse by requiring that these services be provided only in the appropriate treatment setting.
- **Ensuring Medicare Does Not Pay For Claims Owed By Private Insurers.** Under this proposal, private insurers would be required to report to Medicare any beneficiaries they cover. Also, Medicare would be allowed to recover double the amount owed by insurers who purposely let Medicare pay claims that they should have paid, and impose fines for failure to report no-fault or liability settlements for which Medicare

should have been reimbursed.

- **Enable Medicare to Negotiate Single, Simplified Payments for Certain Routine Surgical Procedures.** This proposal would expand HCFA's current "Centers of Excellence" demonstration that enables Medicare to pay for hospital and physician services for certain high-cost surgical procedures through a single, negotiated payment. This lets Medicare receive volume discounts and, in return, enables hospitals to increase their market share, gain clinical expertise, and improve quality.
- **Establish a New Incentive Program To Provide Funding for States to Build a Baseline Measurement for Medicaid Fraud and Errors.** Developing a Medicaid error and fraud baseline would help States to identify areas of the program, target program integrity resources more effectively, and improve States' ability to measure the success of their efforts to reduce errors and eliminate fraud. Funding for the incentive program, \$5 million annually, would come from the Health Care Fraud and Abuse Control program created by the Health Insurance Portability and Accountability Act of 1996.

This Comprehensive Plan also compliments our successful efforts in implementing the 1996 Corrective Action Plan (CAP) to address the Chief Financial Officer's (CFO) Act audit. We look forward to future success in implementing the 1997 CAP, which will work in tandem with this plan to confront many of the same program integrity issues.

Building on these activities, in March, 1998, HCFA sponsored a National Fraud, Waste and Abuse Conference to provide a forum for discussing new and innovative methods of fighting all types of fraud and abuse. Many private industry and government representatives joined in this discussion, which yielded many valuable ideas.

We have made significant progress in our fraud and abuse efforts, but we know there is still a lot of work to do. Dr. Malcolm Sparrow in his book *A License to Steal*, highlights the need for HCFA to take more innovative action against health care fraud and abuse.

It is our hope that the initiatives contained in this Comprehensive Plan for Program Integrity further develop the arsenal necessary to combat fraud, waste and abuse in HCFA's programs, taking us a step forward in preserving Medicare and Medicaid resources for future generations and protecting beneficiaries from harm.

HCFA's Program Integrity Strategy and Goals

Promoting the fiscal integrity of HCFA programs is an overarching goal in HCFA's Strategic Plan. The Strategic Plan directs HCFA to improve its position as an accountable steward of Medicare and Medicaid program dollars and to take aggressive actions to eliminate fraud and abuse. Accordingly, maintaining the program integrity of Medicare and Medicaid is one of HCFA's top priorities--the Agency is committed to attacking health care fraud, waste, and abuse.

We define program integrity very simply: "pay it right." Thus, our overarching program integrity strategy focuses on paying the right amount, to legitimate providers, for covered, reasonable and necessary services provided to eligible beneficiaries. We work to ensure that claims are paid right the first time by applying the following four principles to our program integrity work: prevention, early detection, enforcement, and coordination.

As described in our Annual Performance Plan (to be released with the FY 2000 Budget), all of our program integrity efforts, including the short-term initiatives discussed in this plan, center around accomplishing two major performance goals: ensuring that claims are paid right the first time and reducing our claims payment error rate from 11 percent in 1997 to five percent by the year 2002. These efforts work to protect our beneficiaries from the financial losses and impaired quality of care they can incur as a result of health care fraud, waste, and abuse. In addition, these efforts work to preserve Medicare and Medicaid resources for generations to come.

HCFA recognizes that its program integrity net must be cast wide across the Agency, involving nearly all aspects of the work HCFA performs. We also understand the critical nature of collaborating with our external partners and agents to ensure that we "pay it right." While this plan is intended to compliment the many worthwhile law enforcement efforts undertaken by the Department of Justice (DOJ) and the OIG, its scope is centered around HCFA's goal to "pay it right."

Current and Ongoing Medicare and Medicaid Activities

Listed below are examples of current HCFA operations to ensure that we pay the right amount to legitimate providers for reasonable and necessary services furnished to eligible beneficiaries. This list is by no means all inclusive, but is intended to generally describe the breadth of our current operations and their relation to program integrity.

TO ENSURE THAT HCFA IS PAYING THE RIGHT AMOUNT, WE

- Standardize reimbursement and payment methods by
 - Using Medicare Fee Schedules to pay physicians, durable medical equipment (DME) suppliers, and laboratories.
 - Developing risk adjustment payment systems for managed care.
- Make only appropriate reimbursements and payments by
 - Reviewing claims before they are paid to prevent improper payments.
 - Reviewing claims after they are paid to identify and recover overpayments.
 - Developing separate Medicare Integrity Program (MIP) contractors dedicated to fraud and abuse activities.
 - Educating providers about coverage and payment policies.
 - Auditing hospital, skilled nursing facility, and home health cost reports.
 - Auditing managed care health plans.
 - Ensuring that Medicare and Medicaid are the proper payors.
 - Ensuring that claims are correctly coded.
 - Suspending payments when abuse is strongly suspected.
 - Aggressively assessing and collecting overpayments.
- Work with Law Enforcement by
 - Continuing the principles of ORT.
 - Distributing HCFA-issued Fraud Alerts.
 - Supporting the OIG's issuance of Special Fraud Alerts.
 - Encouraging the use of shared information such as HCFA's Fraud Investigation Database.
 - Ensure that contractors will support law enforcement case development.
 - Promoting the OIG Fraud Hotline and working with the OIG in its initiative to improve the quality of calls received and to ensure that referrals are made to HCFA for resolution.
- Work with State partners by
 - Sharing best practices among States regarding most effective data and technology detection uses.
 - Obtaining access to necessary Medicare payment and eligibility data.

- Providing a national forum for State Medicaid agencies.
- Enhancing HCFA and State coordination and collaboration.
- Educate beneficiaries to report suspected fraud and abuse by
 - Alerting them about claims filed on their behalf.
 - Rewarding those who report fraud and abuse.
 - Promoting awareness about their rights under managed care plans.

TO ENSURE THAT HCFA IS PAYING THE RIGHT PROVIDER, WE

- Attract and retain only legitimate providers by
 - Implementing new Conditions of Participation for hospitals, home health agencies, and other providers.
 - Disenrolling providers who violate Medicare and Medicaid requirements.
 - Reviewing applicants for managed care contracts.
 - Surveying and certifying facilities to assure they meet requirements.
 - Conducting site visits to verify provider existence and legitimacy.
- Work with State and Law Enforcement by
 - Encouraging and facilitating the use of shared information such as the OIG Exclusion List of providers excluded from the Medicare and Medicaid programs and the General Services Administration's exclusion list.
 - Increasing the emphasis on managed care reviews of provider networks to identify excluded providers.
 - Collaborating with the DOJ to enhance collection of provider enrollment information.
- Identify suspect providers by
 - Systematically profiling provider billing practices.
 - Reviewing claims to assure the provider is appropriate.
 - Reviewing managed care health plan practices.
 - Conducting site visits to verify provider legitimacy.
 - Facilitating State and Medicare information sharing about suspect providers.
- Educate providers and beneficiaries about Medicare coverage rules, managed care benefits and appeal rights.
- Hold providers and suppliers responsible for failures to identify and bill correct payers.

TO ENSURE THAT HCFA PAYS FOR THE RIGHT SERVICE, WE

- Ensure services are appropriate by
 - Reviewing claims and associated documentation to ensure services were appropriate and needed.
 - Evaluating medical bill coding.
 - Analyzing managed care services.
 - Educating providers about coverage rules.
 - Educating beneficiaries to recognize and report inappropriate services.

- Working with our partners to develop and implement documentation guidelines for certain physician services.
- Encourage local policy development and implementation.

TO ENSURE THAT HCFA PAYS FOR THE RIGHT BENEFICIARY, WE

- Ensure that beneficiaries are eligible.
- Educate providers and beneficiaries about Medicare and Medicaid coverage and eligibility rules.
- Work with our agents and partners in private industry to ensure compliance with Medicare Secondary Payer (MSP) statutes by
 - Pursuing recovery of erroneous Medicare reimbursements to insurers, third party administrators, and employers.
 - Sharing eligibility and coverage information with employers and private industry insurance partners.

Short-Term Program Integrity Initiatives

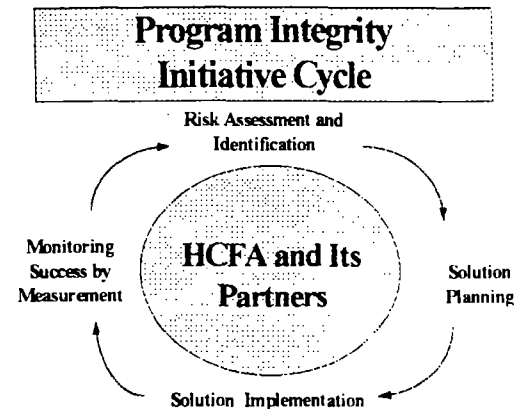
Up until now this document has described the context for this Comprehensive Plan for Program Integrity, as well as our overall program integrity strategy and goals. The next part of the plan discusses how, over the next six to eighteen months, we plan to apply the Comprehensive Plan. It is important to note that some of these initiatives will start within six to eighteen months, but their full implementation will extend beyond this time frame.

- Five of these initiatives involve improving HCFA's program integrity management, i.e., making better use of resources available to us to improve our overall program integrity efforts.
- Three of these initiatives are service specific: they address specific benefit categories that we believe are particularly vulnerable to program integrity issues.

The criteria used for selecting these initiatives were: the amount of benefit dollars at risk if the vulnerability were not corrected, the resources needed to implement the initiative, and/or the capacity to reduce the claims payment error rate. The short-term initiatives will be funded through the Medicare Integrity Program and Peer Review Organization (PRO) budgets.

After selecting the initiatives, we further developed each initiative according to the Program Integrity Initiative Cycle, which is pictured above. This initiative cycle is a way of thinking and visualizing vulnerabilities and their solutions. First, a risk is identified and assessed, i.e., too many unscrupulous providers are entering the Medicare and Medicaid programs. Potential solutions to address the risk are developed in the solution planning phase. After exploring a number of possible solutions, the most effective and viable solutions are implemented and monitored through set performance measures.

In the following pages, we describe the identified risks, as well as our strategy for solution planning and implementation. We are in the process of developing measures to monitor the success of our efforts as they are implemented over the next six to eighteen months.



Improving HCFA Program Integrity Management: Increase the Effectiveness of Medical Review and Benefit Integrity Activities

Risk Assessment and Identification

HCFA's goal is to pay claims properly the first time. However, the complexity of Medicare payment systems and policies, and the numbers of contractors, providers, and insurers involved in the Medicare fee-for-service program create vulnerabilities. In order to minimize these vulnerabilities HCFA is taking specific steps to improve our Medicare medical review and benefit integrity contractor functions to ensure that we pay Medicare claims right the first time.

Medical review activities include all actions, such as medical documentation review, taken to determine the medical necessity of the services provided to a given beneficiary. Benefit integrity includes those activities which are taken to develop fraud complaints, such as data analysis and law enforcement support.

Solution Planning

The OIG's FY 1997 CFO Act audit estimated \$20.3 billion in improper Medicare payments, or an 11 percent claims payment error rate. The errors identified in this audit were identified in the "look behind" review of medical documentation. This means that while the Medicare claims processing systems work well, (i.e., the systems make the right determination based on the information presented on the claim), our medical review and benefit integrity activities, which look behind the information presented on the claim, need improvement in order to reduce the error rate. Accordingly, HCFA is committed to taking specific actions to improve its medical review and benefit integrity activities to reduce the claims payment error rate and preserve trust fund dollars to pay for legitimate services.

Solution Implementation

- **Improve our Medical Review Activities.** We plan to increase the effectiveness of medical review by: (1) increasing the overall level of claims review, including the review of inpatient hospital claims; (2) hiring additional Contractor Medical Directors (CMDs) to assist in improving the effectiveness of medical review; (3) creating more national and local medical review policy; (4) making more efficient use of prepayment review through use of automated edits to "kick-out" claims or potentially auto-deny

claims which do not meet the specifications of a local medical review policy; and, (5) installing commercially developed edits and/or HCFA developed correct coding edits to further enhance our ability to detect improper or improperly coded claims.

- **Targeting Medical Review Resources.** HCFA is targeting medical review to focus on the problem areas identified through the CFO audit, such as durable medical equipment, physician evaluation and management services, and home health claims.
- **Continuing Collaborative Projects.** HCFA will continue to work with its partners, including the DOJ, the Federal Bureau of Investigation (FBI), the Administration on Aging, the OIG, States and others in order to develop collaborative projects in the spirit of ORT which are designed to target abusive practices.
- **Educating the Provider and Supplier Community.** As repeatedly suggested at the March conference, educating the provider community regarding proper documentation requirements will also help improve HCFA's medical review and benefit integrity activities since proper documentation is key in determining the medical necessity and appropriateness of services.
- **Improving HCFA's Efforts in the Medicare Appeals Process.** HCFA will provide improved guidance to Medicare contractors about how to document cases and respond to appeals. HCFA will also investigate legislative or regulatory changes necessary to improve the effectiveness of Administrative Law Judges reviewing Medicare cases.
- **Improve Functional Performance Measures for Contractor Medical Review and Benefit Integrity Activities.** First and foremost, we plan to improve the process for measuring the functional performance of contractor medical review and benefits integrity activities. We are pilot testing an expanded use of a sampling methodology similar to the one used in the CFO audit conducted by the OIG that might help us determine contractor specific error rates. Additionally, we are developing performance metrics for medical review and benefit integrity activities as part of our Medicare Integrity Program implementation activities. If contractors fail to meet set performance standards, HCFA will implement remedies, such as imposing sanctions. Furthermore, contractors will be provided training to enhance their performance.

Monitoring Success by Measurement

Performance measures to be developed as part of the solution implementation phase.

Improving HCFA Program Integrity Management: Implement the Medicare Integrity Program

Risk Assessment and Identification

The Health Insurance Portability and Accountability Act of 1996, created the Medicare Integrity Program (MIP), which provided HCFA with stable, increasing funding for payment safeguard activities, as well as new authorities to contract with entities to perform specific payment safeguard functions. This initiative focuses on implementing our new contracting authority.

Prior to HIPAA, HCFA was limited by law to contracting with our current carriers and fiscal intermediaries to perform payment safeguard activities. As further reiterated at the March, 1998 conference, this created problems because:

- We were not able to gain the benefits of increased contract competition;
- We did not have the authority to contract with new entities even though those entities may be the best qualified;
- Many conflicts of interest were developing as our current contractors entered into managed care and other provider arrangements;
- We were not able to provide incentives specific to program safeguard work,
- Our 72 Medicare contractors were inconsistently performing payment safeguard activities across the country; and
- We were not able to review all services specific to individual beneficiaries because an individual's claims may be processed and reviewed at multiple contractors.

Solution Planning

HCFA has a long-term strategy to implement MIP, which was authorized by the HIPAA of 1996. Under this new contracting authority, HCFA will be competing contracts for three new types of contractors: a Coordination of Benefits Contractor, and Statistical Analysis Contractor, and a Payment Safeguard Contractor.

The Coordination of Benefits Contractor will consolidate all activities associated with coordinating Medicare benefits with private insurers and other government programs into a single entity. This will enable the agency to better manage benefit payments in the correct order of financial liability and thereby reducing erroneous payments.

The Statistical Analysis Contractor, which is discussed later in this document, will provide HCFA with a comprehensive on-going analysis of trends, utilization data and other

information which will assist in the detection of abusive and/or fraudulent behavior.

Specific information regarding the Program Safeguard Contractor piece of our MIP strategy is discussed in further detail below. Additionally, HCFA realizes that we also need to look at how we can change the incentives from paying claims quickly to paying them correctly for our current Medicare carriers and fiscal intermediaries. We also need to explore holding our current contractors liable for claims payment errors.

- **Statutory Principles Will Be Adopted.** The essential principles set forth in the statute will be used: selection through competitive procedures and a community of contractors broader than the one that exists today.
- **Reduction in Number of Contracts.** We will reduce the number of contractors doing payment safeguard activities (all 72 currently perform the work). While the exact number will be determined as we gain experience, the number will be smaller.
- **Local Presence.** The reduction in the number of contractors performing such activities as medical and fraud review as well as audit does not mean that local presence will be eliminated. Medical directors will continue to play an important role in benefit integrity activities, and we intend to retain locally-based Medical directors as well as to continue our relationship with local physicians by using groups like Carrier Advisory Committees and PROs. Coordination with State Medicaid and Survey agencies will also continue as needed. Locally-based fraud investigators and auditors are also likely to be used.
- **Coordination.** Medical review policies will be coordinated across contractors to ensure consistency but we will still incorporate local practice where appropriate.
- **Consolidation.** Activities such as audit, medical review, and fraud investigation may be consolidated in a contract to ensure that possible fraud and abuse problems are identified and investigated from all angles. Contractors may subcontract for specific activities, such as audit or medical review. We may also have contractors who are only responsible for one function such as audit. As suggested at the March 1998 Conference, such consolidation provides contractors with incentives to focus only on program integrity.
- **Prepayment Prevention.** Additional emphasis and focus will be placed on tools such as prepayment patterns, artificial intelligence, autoadjudication, and other analytic tools that improve prepayment identification of inappropriate payments.
- **Data Analysis.** Use of specialty data contractors will become even more important. These contractors will support the benefit integrity contractors, who will also perform data analysis. HCFA will continue to pursue cutting edge analytic methods and technology.
- **We Will Continue a Coordinated Effort with Law Enforcement.** We plan to continue to work with our partners, including law enforcement and State partners such as survey and certification and Medicaid agencies. The activities of the Medicare

contractors not only initiate work done by law enforcement through identification and referral of cases to the OIG, but also support the ongoing development of these cases for prosecution by the DOJ.

Much of the work in the ORT demonstration has been done by Medicare contractor payment safeguards personnel, despite the lack of funding through ORT for these activities. For example, contractors are key to identification of fraudulent or abusive providers. They refer cases, do audits, medical review, and developmental work for fraud cases. They provide program expertise and instruction for law enforcement personnel, as well as developing documentation and performing data analysis.

- **Implementation Will Be Incremental.** Proceeding cautiously with incremental implementation will allow HCFA to ensure that program safeguard activities remain thoroughly conducted. In addition, we must coordinate with the plans for the Intermediary standard system conversion, Carrier standard system conversion, Durable Medical Equipment Regional Carrier (DMERC) standard system conversion, the BBA of 1997 implementation, carrier and intermediary replacement transitions, and Millennium priorities.

We also need to acquire experience with the primary principles of the strategy. MIP implementation requires (1) a separation of benefit integrity activities from claims processing (including activities such as prepayment editing); (2) an orientation of Medicare to entities who may not have experience with the Medicare program; and (3) a comprehensive process to thoroughly evaluate contractor performance. These are major changes that require thoughtful planning, experience and cautious implementation.

Solution Implementation

- **Regulations.** We have developed regulations to ensure consistency in our approach. These will identify the characteristics of entities who can compete, and more clearly define when a conflict of interest exists. A notice of proposed rulemaking was issued March 20, 1998.
- **Developing Statements of Work for MIP Contracts.** Contracting under the Federal Acquisition Regulations is very different from contracting under Title XVIII. We have developed an entirely new statement of work (SOW) for the Program Safeguard Contractor contract. A draft of the SOW was released to the public on April 6, 1998.

Work has also begun on a SOW for a new statistical contractor, a managed care contractor and the coordination of benefits contractor.

- **Planning Implementation.** The following considerations are helping us decide where to implement the first MIP contractor:
 - Beneficiary dollars at risk,
 - Contractor transitions and capabilities, and
 - Millennium systems implications.

Monitoring Success by Measurement

Performance measures will be built into the new MIP contracts to monitor the success of their program safeguard work.

Improving HCFA Program Integrity Management: Implement Payment Safeguards for BBA Provisions

Risk Assessment and Identification

As articulated at the March, 1998 Conference, the BBA's new coverage and payment policies, such as new covered benefits and prospective payment systems for skilled nursing facilities and home health, introduce a new design appropriate for program integrity protections. While we believe that preventive health benefits are critical to improving the health of our beneficiaries, appropriate program integrity protections are still necessary to ensure that these services are not abused. Program integrity protections will not limit medically necessary access to these new benefits. Further, constraints on systems resources associated with the Millennium will require HCFA to develop new and innovative methods to protect program dollars in these new coverage and payment areas.

Solution Planning

To ensure a seamless and risk averse transition in the implementation of these new coverage and payment policies, program integrity strategies are being developed concurrently with these policies. This proactive strategy development allows HCFA to focus on early detection of problems and potentially abusive patterns and targets resources to emerging fraud, errors and abuse.

More specifically, the BBA has created the following new programs, benefits and reimbursement methods, which while important additions to the program, also pose new vulnerabilities for HCFA's programs.

- New Programs
 - State Children's Health Insurance Program
 - Medicare + Choice
- New or Expanded Benefits
 - Screening mammography
 - Screening pap smear and pelvic exams
 - Prostate cancer screening tests
 - Diabetes self-management
 - Bone mass measurement

- **New or Expanded Reimbursement Methods**

- Prospective payment for skilled nursing facilities
- Prospective payment for home health agencies
- Prospective payment for hospital outpatient services
- Prospective payment for rehabilitation services
- Reimbursement changes for nurse practitioners, clinical nurse specialists, physician assistants, and skilled therapists

New benefits will help to improve the health of Medicare beneficiaries. New programs will expand access and choice for beneficiaries. New reimbursement methods encourage efficiency and ensure that providers are paid fairly for their activities. Nevertheless, with the introduction of any new benefits, programs, or reimbursement methods, opportunities for fraud and abuse follow. Therefore, HCFA is anticipating vulnerabilities and working proactively to minimize them.

Solution Implementation

These changes in the way HCFA reimburses for various programs, benefits, and health care providers create shifting incentives for fraud, waste and abuse. HCFA is anticipating these vulnerabilities and devising new ways to do business from the onset of these changes. For example, HCFA is:

- Redefining medical review and audit in the age of prospective payment, where providers have incentives to provide an inadequate amount and/or quality of services, or to mischaracterize patients' conditions, and
- Exploring its baseline data needs before implementing increased payments to nurse practitioners and physician assistants, so that we can track reimbursement trends for these provider types from the outset.

Monitoring Success by Measurement

Performance measures to be developed.

Improving HCFA Program Integrity Management: Promote Provider Integrity

Risk Assessment and Identification

Provider enrollment refers to all of the activities which occur before we allow a provider to participate in the Medicare and Medicaid programs. The information gathered during the fraud and abuse conference and the experience from our ORT Anti-Fraud initiative, internal HCFA analyses (e.g., Miami Field Office), and reports by the General Accounting Office (GAO) and the OIG point out weakness in our provider enrollment process. For example:

- As part of ORT, the OIG released a study on vulnerabilities in the DME arena which indicated that enrollment in Medicare as a DME supplier was too easy, making participation possible by unqualified providers and opening opportunities for fraud and abuse. The OIG study found that a significant number of DME suppliers did not have physical business addresses or were located in private homes, and had no actual supply of equipment on the premises.
- The OIG released a report indicating that one quarter of the home health agencies in the five ORT States - New York, Florida, Illinois, Texas, and California - are problem providers, meaning that these home health agencies have abused or defrauded Medicare or misappropriated Medicare funds through the cost report or claims process. Further, these problem home health agencies received almost 45 percent of all Medicare expenditures for home health services in these States. The OIG recommended that HCFA: (1) strengthen its ability to identify problem providers, (2) prevent problem providers from entering the program, and (3) prevent the Medicare trust fund from incurring further losses due to the activities of problem home health agencies.
- The OIG has been conducting a number of reviews of partial hospitalization services provided through Community Mental Health Centers (CMHCs). Joint reviews between HCFA staff and OIG offices in Florida and Pennsylvania showed that in 14 CMHCs, requirements to qualify as a CMHC were not always met; most of the beneficiaries were found to be ineligible for partial hospitalization services; many of the services provided to beneficiaries were not reasonable and necessary; and provider cost reports contained costs that were not always allowable or reasonable and necessary.

Solution Planning

Many participants at the National Fraud, Waste and Abuse Conference held in March of 1998 recommended that we strengthen our provider enrollment activities. Enhancing our current provider enrollment activities is a very effective way to make the Medicare and Medicaid

programs less vulnerable to unscrupulous providers of all types and stop fraud and abuse before it happens. Developing stricter standards, developing stronger conditions of participation, conducting onsite visits to verify legitimacy and compliance with standards, requiring surety bonds, and collecting better ownership and financial solvency information are all provider enrollment activities which enhance our ability to prevent bad providers from entering the programs.

Certain actions have been proven to be effective tools in stopping unqualified, unscrupulous providers from entering the Medicare program. For example:

- The success of the DME on-site visits in South Florida and parts of New York, Illinois, California, and Texas demonstrate the effectiveness of site visits in fighting fraud and abuse. Site visits in the previously mentioned five States in FY 1997 resulted in Medicare billing revocation for 570 of 1,777 existing DME suppliers and denial of billing numbers for 79 of 174 new applicants.
- Regulations to strengthen home health agency enrollment were developed during the recent home health moratorium. These regulations would, when fully implemented, require home health agencies to post surety bonds and establish minimum capital requirements in order to further ensure the legitimacy and solvency of the home health providers.
- HCFA suspended payment and terminated the provider numbers of a number of CMHCs in response to reviews conducted by HCFA and the OIG. HCFA has also referred a number of these facilities to the OIG for further investigation.

Solution Implementation

Building on past activities, following are some suggested components of an overall initiative which would strengthen many of these provider enrollment activities to help keep the unscrupulous providers out of the Medicare and Medicaid programs.

- Perform more onsite reviews to verify enrollment information.
- Revise the Medicare provider/supplier enrollment regulation to expand our authority to require and collect pertinent information and periodically re-enroll providers.
- Develop regulations that implement the Secretary's authority to require surety bonds for other providers.
- Work with the OIG and providers to assist in the development of compliance plans.
- Hold providers and suppliers responsible for failures to identify and bill third party payers primary to Medicare.

Monitoring Success by Measurement

Performance measures to be developed.

Improving HCFA Program Integrity Management: Initiate Millennium Contingency Planning

Risk Assessment and Identification

HCFA's overall Millennium goal is to maintain a basic level of uninterrupted service for our customers regardless of automated systems failure, whether they be failures of our own systems or those of critical outside sources. Achieving this goal requires a significant effort at developing contingency plans to ensure continuation of our core business process during any Millennium-related systems failures.

Inherent in this effort is ensuring program integrity during any systems-related crisis by incorporating program safeguards into any relevant business process contingency plans.

Solution Planning

Contingency plan program safeguards must protect against actions by "outside" entities (e.g., unscrupulous providers) who may try to take advantage of any perceived vulnerabilities in our payment processing systems, as well as against threats to the integrity of our programs presented by failure of our own internal systems.

Solution Implementation

HCFA has created an Agency-wide contingency planning staff to conduct and manage Agency-wide contingency planning efforts. Program integrity issues are an integral part of this effort, thus HCFA's final contingency plan will contain a significant program integrity component.

We are also planning on establishing a Program Integrity contingency workgroup to assess the program integrity implications of all enterprise contingency plans.

Monitoring Success by Measurement

Performance measures to be developed.

Addressing Service Specific Vulnerabilities: Inpatient Hospital Care

Risk Assessment and Identification

In 1996, Medicare paid over \$94 billion dollars in inpatient hospital claims. Inpatient hospital claims were identified as a program integrity problem area when the OIG conducted their FY 1996 and FY 1997 CFO audits. Inpatient hospital claims comprised about 20 percent of the errors identified in the FY 1996 and FY 1997 audits or \$4-5 billion in trust fund losses each year. Inpatient hospital claim errors are significant because inpatient hospital claims are the most expensive claims Medicare program pays.

Solution Planning

The errors identified through the audit were due mostly to hospitals providing services which were medically unnecessary or uncovered, hospitals failing to supply medical documentation to support the services provided, and hospitals incorrectly coding inpatient claims.

Solution Implementation

In response to the finding of the CFO audits, HCFA has implemented an aggressive corrective action plan intended to reduce the overall rate of erroneous payments from ten to five percent of total dollars by the year 2002. As part of this effort HCFA is planning a multi-faceted strategy designed to target the abuses identified in the inpatient hospital setting. Central to this effort is the role of PROs.

PROs will continue to perform current activities such as validating diagnostic information to confirm correct Diagnosis-Related Group assignment and reviewing medical records referred by fiscal intermediaries and OIG.

A dozen PROs are currently conducting program integrity pilot efforts. These are not only expected to have short-term impact on the error rate, but also to serve as road maps to help other PROs move quickly into this work.

In addition to these efforts, in the next contract cycle (the sixth Scope of Work), PROs will use their analytic capabilities to identify suspect patterns of activity using Medicare claims and other data. PROs will then choose from their full array of options to identify, investigate, correct, and prevent erroneous payments (e.g., medically unnecessary services, inaccurate coding of claims, or attempts to circumvent Medicare payment rules). PROs will:

- Conduct case review,
- Participate in joint activities with Fiscal Intermediaries and State agencies,
- Educate providers,
- Provide comparative data for facilities and practitioners to guide improvement, and

- Refer information to OIG or other appropriate authorities about potential findings of fraud.

PROs will not be alone in examining program integrity in hospitals. Through other contractors, HCFA will be doing more cost report audits and reviewing Medicare Secondary Payer situations in the inpatient hospital setting.

Monitoring Success by Measurement

HCFA's Office of Clinical Standards and Quality will design and support a system to measure and monitor the national and State-level inpatient payment error rates, based on a standardized medical review of a random sample of inpatient hospital charts. These reviews will be similar to the CFO audit's substantive testing process. HCFA will have performance-based contracts with each PRO under which its success will be judged by changes in the inpatient payment error rate. HCFA's goal is to reduce this measure to 5 percent or less by the end of the contract cycle, in 2002.

Addressing Service Specific Vulnerabilities: Congregational Care

Risk Assessment and Identification

When groups of beneficiaries, regardless of their health status, congregate in one location (skilled nursing facility, custodial care, adult day care, etc.) they become easy targets for unscrupulous providers seeking to abuse our programs. The types of congregational care facilities vary by State, each having its own temptations and incentives for Medicare and Medicaid fraud and abuse.

Anecdotal evidence and the limited data available depict two distinct fraud and abuse vulnerabilities when beneficiaries congregate in a single location.

- **“Gang Visits”:** Unscrupulous providers can conveniently maximize their fraud and abuse efforts by focusing their efforts on pools of incapacitated and vulnerable beneficiaries. Often, the fraud and abuse involving “*gang visits*,” as they are called, occurs in two ways:
 - Services and supplies are provided to most or all of a group of congregated beneficiaries, whether or not the service or supplies were medically necessary.
 - Providers and suppliers bill for services and supplies not furnished and can do so easily because the congregational nature of the beneficiaries gives easy access to Medicare and Medicaid numbers.

These “gang visits” are a concern with many different types of services and suppliers, with the extent of the fraud and abuse in each benefit depending largely on trends within a geographic location.

- **Duplicative Payments:** Some State Medicaid programs reimburse custodial care facilities for a complete package of services per beneficiary. Many beneficiaries also qualify for Medicare services which duplicate services the custodial care provider is required, and has been paid by the State, to furnish. This results in *duplicative payments* for one set of services. Duplicative payment may also be a problem when other payers, including private insurers and beneficiaries, pay for custodial care services when Medicare is also billed.

Recent OIG and GAO reports highlight the inherent vulnerability of congregated beneficiaries. For example, the OIG released a report in 1996, detailing mental health services in nursing facilities which were found to be medically unnecessary, highly questionable, and billed incorrectly. ORT/Wedge projects have also focused on congregational care, as have individual Medicare contractors, all noting that these issues require more intensive attention.

While the OIG and GAO reports, and ORT projects have focused on a specific array of services provided to beneficiaries, this suggests that there are systemic problems regarding services

provided to pools of beneficiaries. The recommendations yielded from OIG and GAO reports are specific to those services studied, but do not address the larger systemic problems at hand. The Congregational Care Initiative strives to accomplish this.

Solution Planning

The following, most of which were recommended at the March conference, are suggested components of a short-term Congregational Care Initiative:

- Assessment of HCFA data and systems requirements necessary to adequately capture the scope and magnitude of the problems regarding congregational care. As previously noted, part of what creates vulnerabilities for HCFA revolves around HCFA's limited abilities to collect and analyze data regarding services provided to pools of beneficiaries.
- "ORT style" projects that maximize the knowledge base on the frontlines of congregational care, e.g., State based projects.
- Anticipation of shifting incentives for congregational care fraud and abuse under the skilled nursing facility and home health prospective payment systems and building in measures to address these incentives.
- Education of providers, beneficiaries, advocacy groups, and the general public.
- Evaluation of facility responsibility for oversight of care

Solution Implementation

An agency wide workgroup will be assembled to discuss the effectiveness of each of these potential solutions and implement the best strategies to mitigate this vulnerability.

Monitoring Success by Measurement

Performance measures to be developed.

Addressing Service Specific Vulnerabilities: Managed Care

Risk Assessment and Identification

The presence of managed care brings shifting incentives for fraud and abuse, such as the incentive for providers to provide an inadequate amount and/or quality of health care services. The implementation of Medicare+ Choice, which was enacted with the BBA of 1997, will increase the number of Medicare beneficiaries opting to participate in managed care arrangements. Also, in recent years, there has been a proliferation of managed care in the Medicaid program, increasing Medicaid managed care enrollment.

Solution Planning

We are initiating a three-pronged strategy to mitigate the risks posed by the growth of managed care in the Medicare and Medicaid programs. Our strategy includes: implementing a Payment Safeguard Contractor (PSC) for Medicare managed care in a specific geographical area; increasing the effectiveness of our current enforcement tools to monitor the performance of Medicare managed care plans; and developing more safeguards to monitor Medicaid managed care plans.

Solution Implementation

Managed care has created new vulnerabilities, which HCFA is looking to minimize through new and innovative tactics. HIPAA of 1996 enacted the Medicare Integrity Program which granted HCFA new and more flexible payment safeguard contracting authorities. Using this new contracting authority and given the new vulnerabilities of managed care, HCFA will implement a managed care Payment Safeguard Contractor (PSC) in a specific geographical area to be named later. The rationale for implementing a managed care PSC is similar to the rationale for implementing fee-for-service CMDs. By implementing a managed care PSC, HCFA will be exercising its statutory authority to build on current payment safeguard work. Additionally, HCFA will be encouraging competition and contracting with an entity with managed care experience. As suggested at the March, 1998 conference, a managed care PSC will allow HCFA to further define, prevent, and detect managed care fraud, waste and abuse. A PSC will also allow HCFA to develop new ways to address the fraud and abuse vulnerabilities created by managed care. As we learn more about fraud and abuse in managed care we can tailor our tactics and develop new tactics to further minimize our vulnerabilities.

Following are some examples of functions we believe the managed care PSC might perform as our needs become more defined:

- Development of strategies and data sources for verifying MCO reported information regarding beneficiary status. Determine strategies for using encounter data to determine payment rate status.

- Verification of strategies and data sources through audits of HCFA data, State data (Medicaid), and MCO data.
- Validation of beneficiary institutional status.
- Validation of Medicare Secondary Payor working aged status.
- Validation of encounter data, needed for risk adjustment, which is submitted to HCFA by each managed care plan.
- Validation of network contracting requirements.
- Review of beneficiary appeals to determine if access to services is being inappropriately denied.
- Audits of ACRs.
- Conduct aggressive review of MCO compliance with contractual requirements. Reviewing some aspects of the managed care contracts will allow for a more focused review of issues that have been highlighted in GAO, OIG, and HCFA internal reports.

It is important to note that where either HCFA or a managed care PSC finds evidence of suspiciously inaccurate managed care data, HCFA will be vigilant about referring this evidence to our own internal corrective or sanctioning systems, or, when appropriate, to the OIG. HCFA will obtain data to validate a MCO's certification to ensure that enrollment, encounter, and other data is accurate, to enforce violations, and ensure the protection of not only trust fund dollars but beneficiaries' access to care as well.

HCFA will clearly continue work with States to identify and resolve Medicaid managed care program integrity issues. In addition, the National Medicaid Fraud and Abuse Initiative's work to develop guidelines, procedures, new approaches, and data systems to help States control Medicaid managed care will continue.

Monitoring Success by Measurement

Performance measures to be developed as part of the managed care payment safeguard contract.

Resources to Support Strategy and Goals

Technological and financial resources, among others, are critical to the successful implementation of the Comprehensive Plan for Program Integrity. HCFA is currently determining the extent of the technological and financial resources necessary for plan implementation and developing plans for data and technology, as well as for budgeting and funding. We continue on a more detailed level to explore the resources necessary to support our initiatives, but do not anticipate that the proposed short-term initiatives in this plan will require funding sources aside from MIP and PRO funding.

Data and Technology Plan

Taking advantage of new data capabilities and new technology is key to the continuous improvement of our program integrity strategy. We are planning for our data and technology needs by developing a data and technology plan which will discuss our efforts in four distinct areas: HCFA's in-house data needs, Medicare contractor's data and technology needs, how HCFA will make use of commercially available products, and how HCFA is planning for the future procurement of a Statistical Analysis Contractor (SAC).

- **In-House:** Recently, HCFA established a fraud, waste and abuse data analysis group which is working with external resources to "mine" fraud and abuse trends. The data supplied by this group helped to form the service specific initiatives discussed previously in this paper. HCFA has also developed the in-house HCFA Customer Information System (HCIS) which enables HCFA and its contractors to view provider or service utilization data and identify aberrancies at several levels, including the individual provider level. We plan to continue to assess and develop our in-house capabilities for mining and manipulating data to detect fraud, waste and abuse and target our resources to address these problems. Our partners in the Health Resources and Service Administration are also developing a future data tool, the Adverse Action Database, which will assist in identifying potentially abusive providers.
- **Medicare Contractor:** HCFA's development of early detection tools at the national level has been complemented by continuing investment in analytic tools used by HCFA contractors. The Service Tracking, Analysis and Reporting System (STARS) and the Super Operator are two software packages which are used by a number of contractors. These programs compile and analyze claims data and use statistical analysis to identify aberrant utilization profiles.
- **Commercially Available Products:** HCFA will be installing commercially developed edits into its claims processing systems. HCFA is also working with external resources to inventory the off-the-shelf software currently used by our contractors, as well as to do a comprehensive market survey of other commercially available program integrity technology. Further, HCFA will be developing a systematic evaluation of these

products to ensure rapid dissemination of the most effective products. In addition to these efforts, Los Alamos National Laboratories, under contract with HCFA, continues to research new methods of fraud, waste and abuse detection.

- **Statistical Analysis Contractor:** As part of the Medicare Integrity Program, which is discussed in further detail earlier in this paper, HCFA will be awarding a SAC to provide comprehensive on-going analysis of trends, utilization rates, billing patterns, referral patterns, and other related information. These contractors will be modeled after our successful work with the statistical analysis contractor who supports our four Durable Medical Equipment Regional Carriers in detecting specific areas for fraudulent behavior.

In addition, as a long-term strategy, HCFA will conduct a thorough assessment of currently used technology such as the Common Working File and the Medicare contractor shared systems to determine the extent to which they enhance pre- and postpayment review of claims.

Budgeting and Funding Plan

HIPAA of 1996 shifted HCFA's payment safeguard funding from a discretionary appropriation subject to annual budget fluctuations to a mandatory draw against the Medicare Part A trust fund. Accordingly, the passage of HIPAA provided a stable and increasing funding source for HCFA's payment safeguard activities as specified in the MIP. HIPAA provides specific maximum and minimum funding levels for the period of FY 1997 through FY 2002. After FY 2002, the MIP funding remains constant at a level of \$710 to \$720 million per year.

HIPAA requires HCFA to ensure that Medicare contractors separate contractor program management (PM) activities from payment safeguard activities to ensure that MIP funds are allocated only to payment safeguard activities. Therefore, HCFA is establishing an operational framework for requesting and distributing MIP funding provided under HIPAA, as well a process to effectively review and manage the payment safeguard funding provided by Congress. The goal of this process is to increase the efficiency of current and future MIP investments and to support the strategic and business goals of the Agency. There are four phases of the process: project formulation, project review and evaluation, project approval and implementation, and project evaluation.

OIG comments

PRESIDENT CLINTON SENDS CONGRESS NEW PROPOSALS AND TAKES OTHER STRONG STEPS TO FIGHT FRAUD AND ABUSE

December 4, 1998

PROPOSED NEW LEGISLATIVE PACKAGE SAVING MEDICARE OVER \$2 BILLION OVER FIVE YEARS. The Administration is proposing a legislative package to combat fraud, abuse, and waste that will save Medicare over \$2 billion dollars over 5 years in the FY2000 budget. Highlights of this proposal include:

Eliminating Wasteful Excessive Medicare Reimbursement for Drugs. This proposal would eliminate the mark-up for drugs by basing Medicare's payment on the provider's actual acquisition cost of the drug. *5-year savings: \$690 million (OACT estimate)*

Eliminating Overpayments for Epogen. In a November 1997 report, the OIG found that the current EPO reimbursement rate of \$10 per 1,000 units exceeds the current cost of the drug by approximately \$1. This proposal reduces Medicare reimbursement to reflect current market prices. *5-year savings: \$320 million (OACT estimate)*

Ensuring Medicare does not Pay for Claims Owed by Private Insurers. Medicare often pays claims owed by private insurers because it does not know that the beneficiary has other insurance which is responsible for the claim. These proposals require insurers to report the Medicare beneficiaries they insure to HCFA, permit Medicare to recoup twice the amount owed by insurers who purposely let Medicare pay claims that are the responsibility of the group plan, and impose fines for failing to report legal settlements for which Medicare should have been reimbursed. *5-year savings: \$690 million (OACT estimate)*

Eliminating Abuse of Medicare's Partial Hospitalization Benefit. Providers often abuse Medicare's outpatient mental health benefits, billing for services in inpatient hospitals or homes. This proposal would require that these services are only provided in the appropriate treatment setting and authorize the Secretary to set additional criteria for partial hospitalization services furnished by community mental health centers. *5-year savings: \$120 million (OACT estimate)*

Implementing the Competitive Bidding Demonstration for Durable Medical Equipment. The OIG recently found that Medicare rates for hospital beds are substantially higher than rates paid by other payers. In January, HCFA will begin a competitive bidding demonstration using market forces to decrease Medicare payment for hospital beds and other durable medical equipment, thereby lowering program costs.

279
Friedman
Note: The OIG
report questioned
\$229 million
in 5 States in 1 year

TAKING NEW ACTIONS TO MAKE MEDICARE CONTRACTORS MORE

ACCOUNTABLE FOR FIGHTING FRAUD. Today, HCFA is also unveiling new steps they are taking to assure contractors are cracking down on fraud and abuse. They are:

Assuring Contractors Report Fraud Complaints to the Inspector General Right Away.

Currently, many contractors wait until they have hundreds of fraudulent claims before reporting them to the Inspector General. Starting next month, HCFA will send a program memorandum to every contractor requiring them to immediately refer ~~fraud complaints~~ to the Inspector General's office for review to ensure that ~~fraudulent actions~~ are identified and addressed expediently.

Awarding First Contracts This Spring That Allows New Fraud Fighting Units to Perform Payment Safeguard Activities.

The Administration fought to include the Medicare Integrity Program (MIP) in the Health Insurance Portability and Accountability Act of 1996 that gave Medicare new authority to competitively contract with new fraud fighting units or "~~Medicare~~ ~~stops~~" that are better equipped to weed out fraud and abuse. Previously, carriers were contracting with the providers whose claims they processed, which gave them little incentive to detect fraudulent claims. This spring, the first fraud fighting units will begin their anti-fraud efforts.

Developing a Comprehensive Plan for Program Integrity. To improve efforts to cut down on fraud and abuse, HCFA is developing a new Comprehensive Plan for Program Integrity to be released in the spring. This report includes important new anti-fraud strategies including promoting appropriate reimbursement of legitimate providers for covered, reasonable, and necessary services provided to eligible beneficiaries. This comprehensive plan outlines a strategy to increase the effectiveness of current enforcement tools, expedite use of new authority to contract with fiscal intermediaries to perform payment safeguard activities, and instruct peer review organizations to examine program integrity and outside contractors to conduct cost report audits.

Asking Congress for New Contracting Authority to Enhance Contractor Performance.

HCFA does not currently have the authority to terminate contractors that do not meet basic performance standards without initiating a long, arduous performance review process — during which the contractor is able to continue serving Medicare beneficiaries. The proposal would give HCFA new contracting flexibility that permits the agency to aggressively oversee general contractor performance, including important program integrity related functions, such as provider enrollment and overpayment collection.

Directing HCFA to Develop a Clearinghouse of Program Integrity Best Practices. In response to the Inspector General's recommendation that HCFA provide opportunities for Medicare contractors to exchange best practices relating the fraud and abuse detection, HCFA will also develop a clearinghouse for Medicare contractors to share effective procedures for identifying fraud and abuse. HCFA will also, for the first time, require contractors to develop specialized medical review policies to identify and address procedures which are widely overused and inappropriately prescribed. (HHS — OMB is recommending and we forgot to address on call. What do you think?)

*suspicious
fraudulent
providers*

*[Note:
try as
not
law
enforcement
personnel]*

fraud is

OMB comments.

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soon

admin.

(62230)

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processing
claims
1-2 + 3
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for

check for accuracy

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managed care
John B.



FAX COVER SHEET



OFFICE OF LEGISLATION

Number of Pages: 6

Date: _____

To: Chris Jennings / Deborah
Adler

From: Bonnie Washington /
Marcy
Oppenheimer

Fax: _____

Fax: 202-690-8168 or 205-5157

Phone: _____

Phone: _____

REMARKS: _____

HEALTH CARE FINANCING ADMINISTRATION

200 Independence Ave., SW
Room 341-H, Humphrey Building
Washington, DC 20201

*EPO can go
not centers of excellence*

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November 16, 1998

**HEALTH CARE FINANCING ADMINISTRATION
Descriptions of FY 2000 Fraud and Abuse Legislative Proposals**

PROPOSALS ALREADY SUBMITTED TO OMB

o Authorize a Demonstration of Independent Home Health Case Management (HCFA 2000/05)

As authorized by the Balanced Budget Act of 1997 (BBA), HCFA is currently developing a home health prospective payment system (PPS) that will include adjustments based upon the beneficiary's health status and ability to perform activities of daily living. Under current rules, the home health provider would be responsible for performing this assessment of the beneficiary, leaving room for providers to overstate the needs of beneficiaries in order to inflate payments. We propose to request general demonstration authority to charge an independent home health case manager (HHCM) with the task of performing home health eligibility determinations, initial assessments, and reassessments of beneficiaries who may qualify for home health services. The HHCM would also be responsible for plan of care follow-up, assuring ongoing quality care. Only home health agencies in the designated demonstration areas would be required to participate in the demonstration. HCFA would require the care managers to be registered nurses. The HHCM would be prohibited from having any financial relationship with any Medicare provider and would be paid on a fee schedule. *scored as 0*

o Allow Home Health Agencies to Secure Only One Bond for Both Medicare and Medicaid (HCFA 2000/06)

scored as 0

BBA requires home health agencies to obtain a surety bond of at least \$50,000, and requires that agencies participating in both Medicare and Medicaid obtain a bond for each program. This proposal would allow agencies to obtain a single bond, naming both HCFA and the Medicaid state agency as dual obligees. This proposal would keep the cost of surety bonding to a minimum while preserving the benefits of the bonding requirement. HCFA has already issued program instructions that allow home health agencies with combined Medicare/Medicaid reimbursements of \$334,000 or less to purchase a single bond for both programs, in response to concerns that small agencies were having difficulty obtaining two bonds. This proposal would provide a specific statutory basis for this rule and expand it to include all home health agencies.

o Provide 75% Federal Financial Participation for State Agency Administrative Costs Related to Fraud and Abuse (HCFA 2000/08)

Currently, states receive rates of federal financial participation (FFP) that vary depending on the activity -- for example, states receive 75% FFP for their Medicaid Fraud Control Units (MFCUs) and for automated claims processing systems (MMIS), but 50% for most administrative activities.

Many of the new programs and services that states use to identify fraud and waste are outside the definition of MMIS, and are used prior to referral to a MFCU, and therefore do not now qualify for 75% FFP. This proposal would raise the FFP for these programs and services, encouraging states to bolster their anti-fraud activities.

① **Terminate Medicare Benefits of Incarcerated Felons (HCFA 2000/32)**
cost shifting to DOJ. John doesn't like.

Currently, incarcerated felons are entitled to Medicare benefits, though they lose entitlement to Social Security benefits. Prisoners are entitled to Medicare benefits when the prison health care system imposes cost sharing on the prisoner. This proposal would require the state or federal prison system to bear the cost of health care for incarcerated felons. It would also prevent felons from selling their Medicare numbers, thereby serving to avert both fraud and cost-shifting.

1999 PROPOSALS SOON TO BE RE-SUBMITTED TO OMB

MEDICARE

o **Reduce Misuse of Partial Hospitalization Services by CMHCs (HCFA 99/46)*, ****

These two proposals would prohibit providers from furnishing partial hospitalization services in a beneficiary's home or in an inpatient or residential setting. They would also authorize the Secretary to set additional standards or requirements for services furnished by community mental health centers (CMHCs). Partial hospitalization is a very narrow benefit intended only for persons in acute psychiatric distress who, but for these intensive services, would likely be hospitalized. However, the benefit has been frequently abused. These proposals would reduce the abuse of the partial hospitalization benefit and improve the Medicare program's ability to screen out unqualified CMHC providers. *Got 100M/5*

o **Create Civil Monetary Penalties for False Certification of the Need for Care (HCFA 99/31)*, ****

This proposal would create new civil monetary penalties for false certification of the need for partial hospitalization and hospice services when the certifying physician knows that the beneficiary does not meet eligibility criteria for such services.

o **Require Private Insurance Companies to Provide Medicare Secondary Payer Information (HCFA 99/36)*, ****

Currently, there is no requirement that group health plans let Medicare know about those beneficiaries for whom they provide primary coverage. Medicare faces numerous hurdles in recovering mistaken payments for beneficiaries who have private health insurance. This proposal would require all group health plans to provide information that will enable Medicare to identify

Travelers need to report

beneficiaries who have other coverage. As a result, HCFA would know immediately whether Medicare was responsible for making the primary payments for health care services.

o Require Insurance Companies to Report Liability and No Fault Insurance Payments for Medicare Beneficiaries (HCFA 99/34)*

Currently, no fault and liability insurance companies are not required to notify Medicare when a beneficiary has been involved in an accident and a no fault or liability insurance settlement is paid. As a result, Medicare is often billed for services and makes a conditional payment in cases where another party should have assumed primary payment. Providers and suppliers of services rarely notify Medicare of situations in which it is the secondary payer. If medical expenses for an accident are mistakenly paid by Medicare, the program must be reimbursed by the insurance settlement. This proposal would require insurance companies to notify Medicare of any liability and no fault insurance payments made to Medicare beneficiaries or health care providers for health care services.

o Impose Double Damages When a Third-Party Payer Fails to Acknowledge its Status as Primary Payer (HCFA 99/37)*

Currently, the government can collect damages in recovering mistaken Medicare primary payments from third-party payers that have failed to comply with Medicare secondary payer provisions. Unfortunately, some private insurers, who by law are obligated to pay a medical claim before Medicare, purposely fail to pay the claim for which they are responsible knowing that Medicare will inadvertently pay the bill. This proposal would allow Medicare to recoup double the amount owed by the insurer in these cases.

o Permit Medicare and Medicaid to Recover Overpayments and Penalties from Providers that Declare Bankruptcy (HCFA 99/42)*, **

Currently, providers who owe fines or who must return overpayments to the Medicare and Medicaid programs can effectively block recovery by declaring bankruptcy. This proposal would give Medicare and Medicaid the right of first recovery when a provider files for bankruptcy.

o Provide Additional Remedies to End Illegal "Kickback" Schemes*, **

A serious area of fraud is "kickback" schemes, where health care providers unnecessarily send patients for tests or to facilities and receive inappropriate financial rewards. While we have established criminal penalties for these schemes, additional tools are needed to stop this practice. This proposal would allow prosecutors to get a court order to put an immediate halt to such schemes and levy civil as well as criminal remedies. This proposal was developed by DOJ.

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o **Extend Subpoena and Injunction Authority (HCFA 99/39)**

Currently, the Secretary has authority to issue civil monetary penalties in cases of fraud. Included in that authority are the powers of subpoena and injunction. However, these powers are not included in the Secretary's authority for other administrative sanctions such as exclusion. The Secretary needs more powerful tools in order to aggressively investigate fraud, kickbacks and other prohibited activities. This proposal gives the Secretary the authority to require witnesses to appear and produce testimony related to cases involving fraudulent claims, excluded providers who continue to provide services, and other sanctioned activities.

o **Expand Sanctions for Steering or Failure to Provide Services to Plans' Contractors (HCFA 99/27)**

Currently, HCFA can penalize contracting organizations for failing to provide covered services or for screening potential enrollees for health problems. This proposal would expand current protections by allowing the imposition of separate penalties against a health plan's providers, contractors, or agents. These new penalties may be in lieu of, or in addition to, any penalties assessed against the plan directly.

o **Allow Civil Money Penalties for Services Ordered or Prescribed by Excluded Providers (HCFA 99/43)**

Currently, CMPs can be levied against excluded individuals who are furnishing a service, but not against individuals providing a service ordered by an excluded provider. This proposal authorizes CMPs when the individual providing a service knew that the orderer was excluded.

o **Clarify Applicability of Civil Money Penalties (HCFA 99/32)**

Current law contains contradictory language regarding HCFA's ability to impose CMPs in a number of areas involving non-compliance with Medicare rules and regulations. This proposal clarifies HCFA's authority to impose CMPs.

o **Re-establish a "Knowing" Standard for Kickback Penalties (HCFA 99/40)**

A 1995 Ninth Circuit decision interpreted the anti-kickback statute to require "knowing and wilful" action. This proposal would remove the requirement that the government prove "wilfulness," making the burden of proof more similar to that of other criminal statutes.

o **Reinstate Reasonable Diligence Standard For Imposition of CMPs (HCFA 99/44)**

CMPs can be imposed in cases of false claims for Medicare reimbursement. HIPAA altered the legal burden of proof for the government, making providers liable only if they acted with "deliberate ignorance" or "reckless disregard" of the truth. This proposal would return to the previous standard of "reasonable diligence" for imposing CMPs for false Medicare claims.

generic drug proposals. \$125M/5

o **Impose CMPs for Failure to Submit Diagnosis Information as Required By BBA (HCFA 99/29)**

BBA requires practitioners to provide certain medical information when ordering certain items or services. There is no penalty for failure to comply with this provision. This proposal would authorize CMPs for failure to comply.

MEDICAID

o **Prohibit Affiliations with Individuals Debarred by Federal Agencies (HCFA 99/12)**

Current law prohibits debarred individuals from participating in Medicaid as providers, but does not prohibit them from affiliating with providers. This proposal would require Medicaid providers to assure that they do not have debarred individuals as employees, consultants, or in other affiliations.

o **Impose a Surety Bond Requirement Upon Providers of Non-Emergency Transportation (HCFA 99/13)**

Non-emergency transportation has grown from \$100 million to a \$1 billion industry in the past five years. States have requested this authority. States would be allowed to except volunteers who are paid only mileage for their efforts in cases where access might be a problem.

o **Impose a Surety Bond Requirement Upon Non-Physician Clinic Operators (HCFA 99/14)**

States have requested this authority.

o **Impose a Surety Bond Requirement Upon Pharmacies (HCFA 99/15)**

This would be an option for the states. States could also set a threshold, for example requiring bonds only of pharmacies that receive more than \$200,000 annually from Medicare.

o **Permit States to Exclude Beneficiaries for State Convictions (HCFA 99/17)**

Currently, states can exclude beneficiaries from Medicaid if the individual is convicted of specific Federal crimes involving the defrauding of Medicaid. This proposal would allow states to prosecute recipients in state court and to use a state court conviction as a basis for exclusion.

- * Part of President Clinton's January, 1998 Radio Address
- ** Part of HCFA's 1998 Fraud Bill
- *** Part of 1999 Budget Bill

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:

- 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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Date: _____

FAX



Health Division



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

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Health Care Financing Administration

1. Medicare Contracting Reform.

In support of the President's FY 1999 Budget, the Administration submitted a draft bill to Congress, *The Medicare Administrative Improvement Amendments of 1998*.

The legislation was intended to improve the Secretary's flexibility in negotiating with Medicare claims processing contractors by removing some of the statutory restrictions that limit the types of contracts HHS can negotiate. The legislation also improved the Secretary's ability to oversee Year 2000 conversions of Medicare contractor systems. The proposal has five major provisions designed to increase competition and reduce costs:

- ▶ **Increases the Secretary's flexibility in contracting for claims processing and payment functions.** Currently, the Secretary is required by law to contract only with health insurance organizations for the administration of Medicare benefits. This proposal would allow the Secretary to contract competitively with any qualified entity, including but not limited to insurance companies (e.g., accounting firms), to perform any of the program functions currently performed by fiscal intermediaries or carriers (e.g., claims processing, answering beneficiary inquiries). Under this authority, the Secretary could take more aggressive action against contractors to ensure their full Y2K compliance.
- ▶ **Authorizes the Secretary to execute combined Part A and Part B contracts.** Currently, the Secretary is required to enter into agreements with fiscal intermediaries for Part A services and contracts with carriers for Part B services. This proposal would give the Secretary authority to execute combined Part A and Part B contracts. There are 17 states in which the company that holds the Medicare carrier contract also serves as the Medicare fiscal intermediary, which results in some administrative overlap. This proposal allows the Secretary to take advantage of potential efficiencies from combined Part A and B contracts.
- **Allows the Secretary to contract for Medicare functions on any basis permitted by the Federal Acquisitions Regulations.** Medicare must contract with intermediaries and carriers on a cost-reimbursement basis. This proposal would change Medicare law to permit the Secretary to follow Federal Acquisitions Regulations (FAR) in administrative contracting, so she could determine on a case-by-case basis the most appropriate contract arrangement — fixed-price, incentive-based, and so forth.
- **Eliminates the special provisions for terminations of contracts with fiscal intermediaries and carriers.** Under current law, the Secretary can only terminate a Medicare fiscal intermediary agreement after the contractor is given notice and provided with an opportunity for a public hearing. This proposal brings Medicare contractors under the same legal framework as other government contractors.

▶ **Authorizes the Secretary to require fiscal intermediaries and carriers to use Year 2000 compliant information technology. HCFA cannot unilaterally require Medicare contractors to be Year 2000 compliant. This provision would establish Year 2000 compliance as a mandatory performance measurement for Medicare contractors.**

Issue 3: Is HCFA fully utilizing its new fraud and abuse contracting authority?

Background. The fee-for-service portion of the Medicare program is administered through a network of fiscal intermediaries and carriers, generally referred to as Medicare contractors. Medicare contractors are insurance companies, such as Blue Cross and Blue Shield and Travelers. Under contractual agreement with HCFA, these contractors handle daily claims processing and pay providers for Medicare-covered services and items used by beneficiaries. Currently, these contractors are also responsible for applying fraud and abuse controls. Medicare fraud units within each carrier are the focal points for coordinating and referring potential fraud cases to the HHS Office of Inspector General. This system was prompted when the program was established in the mid-1960's by concerns

¹³ GAO/T-AIMD-97-176, September 19, 1997; Medicare Automated Systems: Weaknesses in Managing Information Technology Hinder Fight Against Fraud and Abuse.

that the federal government, which lacked extensive claims processing expertise and experience, would prove incapable of providing service comparable to that of private insurers. This arrangement has remained essentially unchanged since 1965.

Need for Change. Two trends have highlighted the need to change this outdated system. First, conflicts of interest have arisen as carriers and fiscal intermediaries become vertically integrated. For example, as part of their commercial activities carriers are contracting with the very providers whose claims they process on behalf of the government; carriers are processing their "own" claims. This reduces their incentive to attempt to detect fraudulent claims and could put other providers at a competitive advantage. Second, it is becoming clear that there are private entities, that are not insurance companies, that have the potential to carry out fraud and abuse activities as well as or better than existing contractors, without conflict of interest concerns.

Kassebaum/Kennedy Change. Responding to these concerns, Kassebaum/Kennedy gave HCFA authority to enter into contracts with a variety of private sector entities to promote the integrity of the Medicare trust funds. Kassebaum/Kennedy sets forth that selection of these contractors will be through competitive procedures and from a pool of bidders broader than the insurance companies that act as intermediaries and carriers for HCFA today. Prior law limited the pool of contractors that could compete for contracts to the insurance companies that act as carriers for Medicare today, thus limiting HCFA's ability to negotiate. A competitive procedure for contracting with entities will allow market forces to function and produce a more cost-effective allocation of resources while decreasing the conflict of interest inherent in today's system.

HCFA Implementation of Kassebaum/Kennedy. HCFA plans to use competitive procedures, as established in the Federal Acquisition Regulations (FAR), to attract a variety of offerors who, HCFA believes, will propose innovative approaches to implement the Medicare Integrity Program. By invoking the FAR in establishing multi-year contracts with an expanded pool of contractors, HCFA hopes to avoid potential conflicts of interest and obtain the best value for taxpayers dollars.

HCFA is currently developing regulations for promulgation, one year after the passage of Kassebaum/Kennedy, to implement the new contracting authority and which they hope to deliver to OMB in the first quarter of FY 1998. HCFA is also working on a statement of work for competitive contracts.

HCFA plans to use this authority to enter into agreements with three types of contractors;

- statistical analysis contractor who will enhance HCFA analytical capabilities and tools;
- a coordination of benefits contractor to develop and maintain information about the coordination of Medicare benefits with beneficiaries who maintain other insurance coverages; and
- program safeguard contractors who will consolidate activities such as audit, medical review, and fraud investigation to ensure that possible fraud and abuse programs are identified and investigated in their totality for all provider types.

HCFA has developed a preliminary contracting strategy for program safeguard contractors. Activities such as audit, medical review, and fraud investigation will be consolidated in a contract to ensure that possible fraud and abuse problems are identified and investigated from all angles. Contracts will not focus on a particular provider type. That is, there will not be contracts simply for home health or durable medical equipment claims. Rather, a contractor will be responsible for all Medicare services in a specific geographic area. This will include all types of providers for any particular beneficiary. Contractors will have speciality units, however, to focus on particular services or provider types. HCFA believes that this scenario will enable a more comprehensive view of problems but will retain the benefits of focus on such areas as durable medical equipment or home health. HCFA is testing new contracting relationships in several Western States that will separate out (and consolidate) payment integrity activities from claims processing.¹⁴ HCFA's target date for awarding the first program safeguard contract is in fiscal year 1999, more than a year from now.¹⁵

HCFA also anticipates developing performance standards for program integrity contractors that will enable them to assess relative performance of contractors who carry out their payment safeguard activities and find replacements for those contractors that are not meeting standards.

HCFA has not yet determined how the new contractors will be paid. HCFA realizes that in order to increase competition for these contracts the agency will have to move to a reimbursement system different than the current cost system used to pay carriers and intermediaries. Fixed price may be an option in the future, but, for the initial implementation, cost plus fixed fee contracts appear to be the best option, until HCFA gains some experience with new types of contractors.¹⁶

Although OMB has not seen a developed plan for undertaking MIP contracting, the theory behind the idea is sound. A competitive procedure will produce a more cost effective outcome. OMB will have an opportunity to review the regulation, which will detail a contracting rule in the near future, and make comments on its contents.

Recommendation. MIP contracting is an effective use of resources. HD staff remain concerned that HCFA has not taken a much more aggressive approach to implementing their new authority, which was first proposed in 1993. We are working with the Office of

¹⁴Linda Ruiz' Oversight Testimony on HCFA's program integrity initiatives, Hearing before the House Committee on Ways and Means on Thursday, October 9th, 1997.

¹⁵GAO/T-HEHS-98-9, October 9, 1997; Recent Legislation to Minimize Fraud and Abuse Requires Effective Implementation.

¹⁶HD staff is investigating the nature of these payment methods and the reasons why we do not currently undertake a fixed fee payment methodology.

Federal Procurement Policy to explore different means by which to expedite the contracting process. We recommend that we passback to HCFA our concern with the progress on MIP contracting and specify December 1 as the date by which OMB would like to receive the contracting regulation.

Contractor reform
broad pool—
not that we can't drop
them; need trigger

HTS appeals
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**SUMMARY OF ADMINISTRATION'S CONTRACTING REFORM LEGISLATION:
INCREASED FLEXIBILITY IN CONTRACTING FOR
MEDICARE CLAIMS PROCESSING**

This legislation proposes reforms to provide for increased flexibility in contracts with Medicare fiscal intermediaries (entities that process claims under the HI program) and carriers (entities that process claims under the SMI program), including contracts with entities that perform both intermediary and carrier functions.

**CARRIERS TO INCLUDE ENTITIES THAT ARE NOT INSURANCE
COMPANIES**

Subsection (a) permits the Secretary to enter into carrier contracts with agencies and organizations that are not health insurers.

**CHOICE OF FISCAL INTERMEDIARIES BY PROVIDERS OF SERVICES;
SECRETARIAL FLEXIBILITY IN ASSIGNING FUNCTIONS TO
INTERMEDIARIES AND CARRIERS**

Subsection (b)❖

- ❖ replaces the current system of nominating fiscal intermediaries by one under which each provider of services (other than home health agencies and hospice programs) is given a choice every five years among fiscal intermediaries proposed by the Secretary (at least one of which has an office in the geographic area of the fiscal intermediary) to act as that provider's single point of contact under the HI program,
- ❖ permits certain providers of services under common ownership or control to select one fiscal intermediary to serve all those providers nationwide,
- ❖ requires the selected fiscal intermediary to make its services sufficiently available to meet providers' needs,
- ❖ requires the Secretary, in evaluating the performance of fiscal intermediaries, to solicit comments from providers of services,
- ❖ makes explicit the authority of the Secretary to assign specific intermediary and carrier functions (such as electronic claims processing) to agencies and organizations that do not perform other functions,
- ❖ replaces current requirements for standards and criteria (for fiscal intermediaries and carriers) with

contract performance requirements, to be developed only after public notice and opportunity for comment,

⌘ clarifies the Secretary's authority to execute combined part A and part B contracts, and

⌘ enacts related minor and technical amendments.

ELIMINATION OF SPECIAL PROVISIONS FOR TERMINATIONS OF CONTRACTS

Subsection (c) eliminates special requirements for termination of contracts with fiscal intermediaries and carriers.

REPEAL OF FISCAL INTERMEDIARY REQUIREMENTS THAT ARE NOT COST-EFFECTIVE

Subsection (d) repeals requirements (for fiscal intermediary standards) that⌘

⌘ standards include the extent to which a fiscal intermediary's determinations (for providers other than hospitals) are reversed on appeal, and

⌘ standards include whether requests for exemptions, exceptions and adjustments to target amounts (for hospitals not under the prospective payment system) are processed within a specified number of days.

REPEAL OF COST REIMBURSEMENT REQUIREMENTS

Subsection (e) repeals the requirement that fiscal intermediaries and carriers be paid on a cost basis.

COMPETITION REQUIRED FOR NEW CONTRACTS AND IN CASES OF POOR PERFORMANCE

Subsection (f) subjects contracts to the competitive requirements that apply generally throughout the Federal Government. However, the subsection permits contracts to be renewed from term to term for fiscal intermediaries and carriers that have been performing satisfactorily, and functions to be transferred among fiscal intermediaries and carriers, without competition.

WAIVER OF COMPETITIVE REQUIREMENTS FOR INITIAL CONTRACTS

Subsection (g) permits the first round of fiscal intermediary and carrier contracts under the new provisions to be entered into without competition.

YEAR 2000 COMPLIANCE

Subsection (h) clarifies the Secretary's authority to require fiscal intermediaries and carriers to use information technology that is year 2000 compliant. Specifically, contractors are required to ensure that any information technology that they use or acquire (1) meets certain requirements included in the definition of 'Year 2000 compliant' under the Federal Acquisition Regulation; and (2) meets such other criteria for year 2000 compliance as the Secretary considers appropriate. The year 2000 requirements would apply only to information technology that the Secretary finds is under the control of the contractor, and the Secretary is authorized to determine a timeframe for compliance.

EFFECTIVE DATES

Subsection (I) provides the effective dates for the amendments added by the section.

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**Medicare Reimbursement for
Hospital Beds in the Home**

Payment Methodology



**JUNE GIBBS BROWN
Inspector General**

**NOVEMBER 1998
OEI-07-96-00222**

EXECUTIVE SUMMARY

PURPOSE

To compare Medicare's rental reimbursement methodology and utilization patterns for hospital beds used in the home to policies utilized by other Federal, State, private insurance companies, and managed care organizations.

BACKGROUND

The Medicare Supplemental Medical Insurance program pays for the rental or purchase of medically necessary Durable Medical Equipment (DME) used in a beneficiary's home when determined by a physician to be medically required. Suppliers receive monthly reimbursement from the Medicare Durable Medical Equipment Regional Carriers based upon a fee schedule. This schedule is limited by the Health Care Financing Administration's (HCFA) established national payment ceilings, and is adjusted annually for inflation based upon the Consumer Price Index. Certain categories of DME, including hospital beds, are reimbursed as "capped rental" items. The fee schedules reimburse a supplier:

- 10 percent of the allowed purchase price for new equipment for each of the first 3 months of rental; and
- 7.5 percent of the allowed purchase price for new equipment for each of the remaining months for which Medicare will make payment.

We surveyed sampled entities from Medicare risk managed care organizations, Medicaid State Agencies, the top 50 health insurance companies as ranked by policies in force, and a listing of companies providing national and local coverage in the Federal Employees Health Benefits program. Overall, we achieved an 82 percent response rate.

This is one of two reports examining Medicare's policies and reimbursement for hospital bed equipment. A companion report, "*Medicare Reimbursement for Hospital Beds in the Home: Prices*" OEI-07-96-00221, compares the reasonableness of Medicare's reimbursement rates for this equipment to those of other medical insurance payers.

FINDINGS

Only Medicare Provides Suppliers Enhanced Reimbursement for Initial Rental Months

Of the respondents surveyed, Medicare was the only insurer that allows a higher rate of reimbursement for rental periods lasting less than 4 months (10 percent of the allowed charge for purchase as compared to 7.5 percent of the allowed charge for purchase for rentals lasting from 4 to 15 months duration).

Almost Half of Medicare Beneficiaries Only Rent Beds During Enhanced Payment Months.

Claims information from January 1995 - December 1996 established that 47 percent of the Medicare beneficiaries rented beds for 3 months or less, two-thirds rented for 7 months or less, and only 12 percent completed 15 months of rental. The relative short rental periods for Medicare patients means that the enhanced rate, which the program pays for the first 3 months, is an important reason Medicare pays more for hospital bed rental than other payers.

Medicare and Most Other Payers Cap the Duration of the Rental Period and the Amount Paid

Medicare caps rental reimbursement at 15 rental months. This policy is comparable to industry practices that limit both the duration and amount of rental reimbursement for hospital beds. Of the 74 respondents, 72 (97 percent) pay for the rental of hospital beds used in the home, with 56 (75.7 percent) capping the duration of rental.

RECOMMENDATION**Eliminate Enhanced Rates for the First 3 Rental Months**

The HCFA should seek legislation to eliminate the 2.5 percent enhanced rate for the first 3 months of rental. We estimate Medicare would annually save approximately \$15 million. Projected over 5 years, Medicare would save over \$74 million.

We realize that legislative action could take some time. Therefore, in the interim, we recommend that HCFA use the authority under the Balanced Budget Act of 1997 to reduce rates overall. This action would make Medicare's method of payment comparable to methods used by other payers. This is further explained in the companion report. Overall, we believe that a combination of both approaches would be best. However, the savings would not be additive.

The savings estimates are based on CY 1996 payments and are not indexed for inflation.

AGENCY COMMENTS

The HCFA concurs with the intent of our recommendation. However, it is deferring a decision on this matter pending receipt of information on hospital bed pricing. At that time, HCFA will assess whether the approach presented in our report is appropriate or whether an alternative pricing method is preferable. Appendix D contains the complete text of these comments. We remain available to provide technical assistance to HCFA on this issue.

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.

**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.

#



Office of Legislation

Number of Pages: 11Date: 10-26To: Devorah AdlerFrom: Marcy OppenheimFax: 456-5557

Fax: _____

Phone: _____

Phone: _____

REMARKS: _____

HEALTH CARE FINANCING ADMINISTRATION

200 Independence Ave., SW
Room 341-H, Humphrey Building
Washington, DC 20201



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

The Assistant Secretary for Planning and Evaluation
Washington, D.C. 20201

OCT 27 1998

James J. Jukes
Assistant Director for Legislative Reference
Office of Management and Budget
Washington, D.C. 20503

Dear Mr. Jukes:

Enclosed is a second set of FY 2000 legislative proposals (A-19s) for the Department of Health and Human Services. This set supplements our initial submission on September 16 and consists of 31 proposals for the Health Care Financing Administration and two related proposals for the Indian Health Service. We seek OMB approval to advance these in the 106th Congress.

The HCFA proposals affect a number of authorities, including Medicaid, Medicare, CHIP, and HIPAA. The two IHS proposals, affecting Medicare and Medicaid, are revisions to proposals previously sent to OMB for which you requested changes and additional information. Also note that we decided not to send forward a proposal to require criminal background checks on all perspective nursing home employees, although we promised such a proposal in our FY 2000 budget submission. In this respect, Congress passed a provision on criminal background checks in the omnibus appropriation bill. We need time to analyze the provision and decide whether additional legislation is needed.

As always, we would be happy to meet with OMB staff to discuss and explain our proposals. Thank you for your assistance in considering our legislative agenda.

Sincerely,


Margaret A. Hamburg, M.D.
Assistant Secretary for Planning
and Evaluation

Devorah -

I've only
included the Fraud &
abuse proposals. Let
me know if you
have any questions.
Mary

FRAUD AND ABUSE AMENDMENTS

HCFA-2000/05

10/14/98

HEALTH CARE FINANCING ADMINISTRATION FISCAL YEAR 2000 LEGISLATIVE PROPOSAL

Home Health Case Management Demonstration

Request General Demonstration Authority for a Home Health Case Management Provision to Control Home Health Fraud, Waste and Abuse Under the Home Health Prospective Payment (PPS) Statutory Provisions

Current Law: To qualify for home health care, a Medicare beneficiary must be homebound, require intermittent or part-time skilled nursing, physical therapy, or speech therapy, and be under the care of a physician. In addition, the services must be furnished under a plan of care that is prescribed and reviewed at least every 62 days by a physician. Once a beneficiary is deemed eligible to receive home health services, Medicare will pay for all medically necessary skilled nursing, physical, occupational, and speech therapies, medical social services, home health aide visits, and durable medical equipment and supplies. Payment is made on a reasonable-cost basis, subject to per-visit limits. Because of the fairly generous payment system, there was little incentive for HHAs to control the amount of services provided to beneficiaries. In fact, the incentive under this system was to provide a large number of short visits to beneficiaries.

The staggering growth in home health costs was addressed by the Balanced Budget Act (BBA) of 1997, which gives HCFA the authority for a prospective payment system for all home health services, effective October 1, 1999. Until that time, BBA mandated an interim payment system (IPS) that took effect October 1, 1997. The IPS was established to control the unsustainable growth in home health spending and the number of visits while the prospective payment system is being developed.

In developing the PPS, the Secretary will consider an appropriate unit of service, the number of visits provided within that unit, and their cost. Payment for a unit of home health service will be modified by a case mix adjustor, set by the Secretary, to explain a significant amount of the variation in the cost of different units of service.

The evidence under the FFS system seems to show that HHAs did behave in accordance with their incentives. First, studies indicate that some beneficiaries who receive home health services do not meet the eligibility requirements of the program, and that those who are actually eligible for home health services receive services that may not be medically necessary (*GAO, OIG reports*). Part of this problem may stem from the fact that physicians do not play as strong a role in developing plans of care for home health services as HCFA envisions (*OIG report*). Often, the HHA itself develops the plan of care independently, while the beneficiary's physician simply signs off on it. While the amount of money Medicare spends on medically unnecessary home health services is difficult to quantify, we may assume that it amounts to hundreds of millions of dollars annually. HCFA's limited resources for pre- and post-payment claims reviews and audits have made detection of these problems difficult.

The goal of a prospective payment system is to ensure that providers have incentives to control costs while still allowing agencies to provide quality services to beneficiaries. Under the Home Health PPS, payment rates to agencies will vary according to a patient's condition and ability to function -- this concept is known as case-mix, and is essential for a PPS to work effectively.

Incentives for HHAs will change under the PPS. Under the FFS system, home health agencies had incentives to provide numerous, short visits to beneficiaries, since payments were made on a per-visit basis. Under the PPS, HHAs will receive a flat payment rate per episode, based on the expected costs of caring for the beneficiary given his/her condition. The incentive will now be for HHAs to provide services at as low a cost as possible, which may lead HHAs to underserve beneficiaries. While we are prepared to detect patterns of underservice through matching of claims data to quality assessment data, this system may not be adequate for detecting underservice on a case-by-case basis, and it will only detect problems retroactively. This is why we view the home health case manager's (HHCM) quality assurance role as a crucial one. The HHCM's quality assurance role would be more proactive, and could begin with working with the HHA to develop a plan of care after performing the initial assessment, and could then consist of performing follow-up reviews of beneficiaries' care records, and occasional home visits or phone calls to beneficiaries to ensure they are receiving satisfactory care.

Proposal: Home health services have traditionally been paid for on reasonable cost basis. HCFA is currently developing PPS for home health services. The BBA of 1997 provides the statutory authority for home health PPS. The BBA also mandates that payments under the PPS be adjusted for case mix. It is expected that payment rates to HHAs for services will be adjusted according to a beneficiary's health status and ability to perform activities of daily living. The initial assessment of a patient and reassessment for subsequent episodes will provide the information needed to determine payment rates. Thus, incentives will exist for providers to overstate the actual needs of beneficiaries in order to inflate payments. A similar phenomenon is seen under the inpatient hospital prospective payment system, and is known as "case mix creep" or "upcoding."

Under the PPS, allowing the home health provider to perform the assessment of beneficiaries makes the system vulnerable to fraud and abuse through "upcoding." We propose to request general demonstration authority to eliminate this vulnerability by charging an independent, HHCM with the task of performing home health eligibility determinations, initial assessments, and reassessments of beneficiaries who may qualify for home health services. Only home health agencies in the designated areas required in the statutory authority would be required to participate in the demonstration.

Rationale: Under the demonstration, if the home health care manager determines that a beneficiary meets the eligibility requirements for receiving home health service, an independent assessment would be performed to identify the beneficiaries' service needs and to determine the episode payment rate made to the home health agency. The home health care manager will also be responsible for plan of care follow-up, a function which will ensure that beneficiaries are receiving medically necessary, high quality home health care. The home health care manager may also have additional functions, including serving as an ombudsman between HHAs and beneficiaries. We believe that the HHCM would need to be a new type of non-governmental entity. The HHCM would be prohibited from having any type of financial relationship with any

Medicare provider. HCFA would require the care managers to be Registered Nurses, and would need to determine a maximum number of beneficiaries each RN could oversee. The HHCMs would be paid for their services on a fee schedule, with separate rates paid for assessments, reassessments and plan of care follow-up activities. The HCFA Regional Offices may be given responsibility for reviewing state agency performance. We anticipate that one home health care management entity would serve each HCFA region. Successful implementation of this proposal would lead to improved outcomes for Medicare home health care beneficiaries, and savings to the Medicare program. We do not believe that it is currently feasible for the HHCM to serve as a more comprehensive, post-acute care manager. However, we do see the possibility for these proposed entities to take on a more comprehensive, across-benefit role in the future.

Effect on Beneficiaries: Under the PPS, allowing the home health provider to perform the assessment of beneficiaries makes the system vulnerable to fraud and abuse through "upcoding". We propose to eliminate this vulnerability by charging an independent, professional home health case manager with the task of performing home health eligibility determinations, initial assessments, and reassessments of beneficiaries who may qualify for home health services.

Cost: Budget neutral.

Effective Date: October 1, 2001.

HCFA-2000/6
10/19/98

HEALTH CARE FINANCING ADMINISTRATION FISCAL YEAR 2000 LEGISLATIVE PROPOSAL

Surety Bond Requirements for Home Health Agencies

Allow HHAs to Secure Only One Bond for Both the Medicare and Medicaid Programs

Current Law: Section 4312 of the Balanced Budget Act of 1997 requires HHAs to obtain a surety bond in an amount that is at least \$50,000 for any services furnished on or after January 1, 1998. Further, HHAs participating in both Medicare and Medicaid must obtain a bond for at least \$50,000 for each program.

Proposal: Allow HHAs participating in both Medicare and Medicaid to secure only one bond for both programs. This would allow a single bond naming both HCFA and the Medicaid State agency as dual obligees.

The single bond would be administered as follows:

o Amount of Bond:

The amount of the single bond would be the greater of \$50,000 or 15 percent of the HHA's combined Medicare and Medicaid revenues.

o Proportional Split for Dual Program Recovery:

For HHAs participating in both programs, the Regional Home Health Intermediary would establish a distribution baseline which would separate out the dollar amounts that the Medicare and Medicaid programs are each initially able to recover from the surety bond during the term of the bond. This could be calculated by taking the combined Medicare/Medicaid reimbursement and dividing it by the HHA's individual reimbursement from each program.

o Example of Percentage Distribution:

HHA's total reimbursement	-- \$333,000
Medicare reimbursement	-- \$233,000
Medicaid reimbursement	-- \$100,000
Amount of bond	-- \$ 50,000

$\$233,000 \div \$333,000 = 70\%$ -- the percentage that Medicare could initially recover.

$\$100,000 \div \$333,000 = 30\%$ -- the percentage that Medicaid could initially recover.

For a \$50,000 surety bond, the Regional Home Health Intermediary could initially

recover ($\$50,000 \times .70 = \$35,000$) \$35,000. For a \$50,000 surety bond, the State could initially recover ($\$50,000 \times .30 = \$15,000$) \$15,000.

Rationale: Some small, upstanding HHAs have experienced difficulty in obtaining a minimum \$50,000 bond each for the Medicare and Medicaid programs as provided by the Balanced Budget Act of 1997. To address this situation, HCFA has issued program instructions that allow HHAs with combined Medicare/Medicaid reimbursements of \$334,000 or less to purchase a single bond for both programs. This proposal would provide a specific statutory basis for this program instruction. This proposal would also expand this program instructions to include all HHAs, regardless of the amount of payments under the Medicare and Medicaid programs. We believe this would increase the availability of surety bonds to those agencies. This would keep the cost of obtaining the surety bonds to a minimum and would reduce significantly the financial burden on HHAs. The regional home health intermediaries would be responsible for overall coordination between HCFA and the Medicaid State agencies for HHAs that meet this qualification.

Effect on Beneficiaries: We believe that this proposal would allow legitimate HHAs to stay in the Medicare and Medicaid programs and continue to provide beneficiary services to those in need.

Cost: Preliminary staff estimate is budget neutral.

HCFA-2000/08

10/14/98

HEALTH CARE FINANCING ADMINISTRATION FISCAL YEAR 2000 LEGISLATIVE PROPOSAL

Federal Financial Participation

Provide 75 Percent Federal Financial Participation for State Agency Administrative Costs Related to Fraud and Abuse Activities

Current Law: Section 1903(a)(3) (see 42 CFR 433 Subpart A Section 433.15) identifies various Federal Financial Participation (FFP) rates appropriate for administration of the Medicaid program. Under this section, the State can receive 90% FFP for family planning and development implementation, and design of an acceptable automated claims processing (MMIS) system. The State receives 75% reimbursement for operation of an MMIS system. 42 CFR 433.15(b)(7) allows reimbursement of other activities of the State at a 50% reimbursement rate, with the exception of the Medicaid Fraud Control Unit (MFCU), which is funded at a 75% FFP rate.

MFCUs are units of State governments that stand apart from the States' Medicaid programs. They are composed of attorneys and auditors experienced in investigating and prosecuting cases of civil or criminal fraud. Medicaid agencies are generally responsible for detecting and uncovering fraudulent activities within their programs. Those cases are then turned over to the MFCUs for additional investigation and prosecution. Because the Surveillance and Utilization Review Subsystem (S/URS) is a part of the MMIS system, the FFP on that operation is 75%.

Proposal: Provide 75% matching funds for all costs associated with fraud and abuse activities conducted by the State Medicaid agency within a distinct program integrity unit or units. This enhanced funding would apply to direct fraud and/or abuse functions that would include, but not be limited to, activities such as identification, investigation, and administrative actions (e.g., recoveries and provider exclusions).

Rationale: The intent of the law, which was developed over 20 years ago, was to encourage electronic identification of problems with Medicaid funding. Since that time, more sophisticated electronic monitoring and detection devices have been developed which enable the States to better ensure that only appropriate services are paid. However, because the new programs and activities are outside the definition of the MMIS system, States can receive only a 50% match for these new activities. If this incentive could increase the activity of the States in this area, it would be both cost effective and would support the Administration's stated goal of reducing fraud and abuse in Social Security funded programs. The fact that the Medicaid Fraud Control Units (MFCUs) are funded at 75% is an indication that there has always been an interest in encouraging program integrity activities.

Effect on Beneficiaries: None.

Federalism Impact: This proposal would result in a 75% Federal Financial Participation rate for

program integrity activities, whether they are conducted by the Medicaid Fraud Control Unit or the State Medicaid agency.

Cost: (in millions)

<u>FY 2000</u>	<u>FY 2001</u>	<u>FY 2002</u>	<u>FY 2003</u>	<u>FY 2004</u>
0	25	5	-5	-10

Effective Date: October 1, 2000.

HCFA-2000/32

10/26/98

HEALTH CARE FINANCING ADMINISTRATION
FISCAL YEAR 2000 LEGISLATIVE PROPOSAL

Incarcerated Felon Benefits

Terminating an Incarcerated Felon's Medicare Benefits

Current law: Individuals who are convicted of a felony and incarcerated are eligible for Medicare benefits. However, these individuals lose their entitlement to Social Security benefits. Generally, if health care services are paid for directly or indirectly by a governmental entity, payment for those services will not be made by the Medicare program (see section 1862(a)(3) of the Act and 42 CFR 411.4(b)). However, an exception to this rule permits correctional institutions to enroll incarcerated felons in the Medicare program.

Proposal: Any individual convicted of a felony who is in the custody of a State or a Federal correctional institution is not entitled to Medicare benefits. This legislation would parallel the entitlement to Medicare with that of Social Security benefits. If an individual's Social Security eligibility is terminated after conviction, then Medicare eligibility would also be terminated. If Social Security is reinstated, then Medicare eligibility would be reinstated. The language of the provision would be similar to section 202(x) of the Social Security Act which limits payments of benefits to prisoners.

Rationale: The elderly population of prisons is the fastest growing population of prisons. More and more correctional institutions are enrolling their eligible prisoners in group health plans, thereby shifting the financial responsibility for their health care to Medicare. Without new legislation to terminate the Medicare eligibility of incarcerated felons, more States will enroll their prisoners in Medicare Part B. These costs should be borne by the correctional institution and not by Medicare.

Effect on Beneficiaries: None. The State or Federal correctional institution would be responsible for providing health care to incarcerated felons. However, States may view this proposal as an unfunded mandate.

Cost: The costs for identifying incarcerated felons would be minimal, given the data match system already in place at SSA.

HHS
Comments

TAKING NEW ACTIONS TO MAKE MEDICARE CONTRACTORS MORE ACCOUNTABLE FOR FIGHTING FRAUD

Today, HCFA is also unveiling new steps they are taking to assure contractors are cracking down on fraud and abuse. They are:

^{HOLD BACK CASES OF SUSPECTED FRAUD BECAUSE DOLLAR AMOUNTS SEEM LOW}
Assuring Contractors Report Fraud Complaints to the Inspector General Right Away.

Currently, many contractors wait until they have hundreds of fraudulent claims before reporting them to the Inspector General. ^{WASTE THIS MONTH REGARDLESS OF AMOUNT.} Starting next month, HCFA will send a program memorandum to every contractor requiring them to immediately refer fraud complaints to the Inspector General's

office for review to ensure that fraudulent actions are identified and addressed expediently. ^{IF LAW ENFORCEMENT DECLINES TO ACCEPT THE CASE WITHIN 90 DAYS, CONTRACTORS WILL BE REQUIRED TO TAKE ACTION TO RECOVER THE MONEY.}

CASES, REGARDLESS OF THE DOLLAR AMOUNT,

Awarding First Contracts This Spring That Allow New Fraud Fighting Units to Perform Payment Safeguard Activities. The Administration fought to include the Medicare Integrity Program (MIP) in the Health Insurance Portability and Accountability Act of 1996 that gave Medicare new authority to competitively contract with new ~~fraud fighting units~~ or "Medicare cops" that are better equipped to weed out fraud and abuse.

Previously, carriers were contracting with the providers whose claims they processed, which gave them little incentive to detect fraudulent claims. This spring, the first ~~fraud fighting units~~ ^{PROGRAM INTEGRITY} will begin their ~~anti-fraud~~ efforts.

Delete this sentence

AND CONDUCT MEDICAL REVIEW, EDUCATE PROVIDERS AND AUDIT COST REPORTS.

Developing a Comprehensive Plan for Program Integrity. To improve efforts to cut down on fraud and abuse, HCFA is developing a new Comprehensive Plan for Program Integrity to be released ~~in the spring~~. This report includes important new ~~anti-fraud~~ strategies including to promote appropriate reimbursement of legitimate providers for covered, reasonable, and necessary services provided to eligible beneficiaries. This comprehensive plan outlines a strategy to increase the effectiveness of current enforcement tools, expedite use of new authority to contract with fiscal intermediaries to perform payment safeguard activities, and instruct peer review organizations to examine program integrity and outside contractors to conduct cost report audits. ^{INSERT (A) BELOW}

Asking Congress for New Contracting Authority to Enhance Contractor Performance.

HCFA does not currently have the authority to terminate contractors that do not meet basic performance standards without initiating a long, arduous performance review process — during which the contractor is able to continue serving Medicare beneficiaries. The proposal would also give HCFA new contracting flexibility that permits the agency to aggressively oversee general contractor performance, including important program integrity related functions, such as provider enrollment and overpayment collection. ^{INSERT (B) BELOW}

Directing HCFA to Develop a Clearinghouse of Program Integrity Best Practices. In response to the Inspector General's recommendation that HCFA provide opportunities for Medicare contractors to exchange best practices relating the fraud and abuse detection, HCFA will also develop a clearinghouse for Medicare contractors to share effective procedures for identifying fraud and abuse. HCFA will also, for the first time, require contractors to develop specialized medical review policies to identify and address procedures which are widely overused and inappropriately prescribed. ^{HHS - OMB is recommending and we forgot to address on call. What do you think?}

PROMOTE BETTER SAFEGUARDS IN MEDICARE AND MEDICAID BY IMPLEMENTING

- (A) IMPROVED MANAGEMENT TOOLS AND TARGETING KEY BENEFIT AREAS FOR PARTICULAR FOLKS. ^{expeditiously}
- (B) NEEDS AUTHORITY TO TERMINATE POOR-PERFORMING CONTRACTORS AND TO EXPAND THE ROL OF COMPANIES THAT ARE ELIGIBLE TO PROCESS AND PAY CLAIMS.

EARLY NEXT YEAR

Legislation (proposed 5 times); move to page one.

Delete

T 456-5777
7431**PRESIDENT CLINTON SENDS CONGRESS NEW PROPOSALS AND TAKES OTHER
STRONG STEPS TO FIGHT FRAUD AND ABUSE**

December 4, 1998

WASTE

**PROPOSED NEW LEGISLATIVE PACKAGE SAVING MEDICARE OVER \$2
BILLION OVER FIVE YEARS.**

The Administration is proposing a legislative package to combat fraud, abuse, and waste that will save Medicare over \$2 billion dollars over 5 years in the FY2000 budget. Highlights of this proposal include:

Eliminating Wasteful Excessive Medicare Reimbursement for Drugs. This proposal would eliminate the mark-up for drugs by basing Medicare's payment on the provider's actual acquisition cost of the drug. *5-year savings: \$690 million (OACT estimate)*

Eliminating Overpayments for Epogen. In a November 1997 report, the OIG found that the current EPO reimbursement rate of \$10 per 1,000 units exceeds the current cost of the drug by approximately \$1. This proposal reduces Medicare reimbursement to reflect current market prices. *5-year savings: \$320 million (OACT estimate)*

Ensuring Medicare does not Pay for Claims Owed by Private Insurers. Medicare often pays claims owed by private insurers because it does not know that the beneficiary has other insurance which is responsible for the claim. These proposals require insurers to report the Medicare beneficiaries they insure to HCFA, permit Medicare to recoup twice the amount owed by insurers who purposely let Medicare pay claims that are the responsibility of the group plan, and impose fines for failing to report legal settlements for which Medicare should have been reimbursed. *5-year savings: \$690 million (OACT estimate)*

Eliminating Abuse of Medicare's Partial Hospitalization Benefit. Providers often abuse Medicare's outpatient mental health benefits, billing for services in inpatient hospitals or homes. This proposal would require that these services are only provided in the appropriate treatment setting and authorize the Secretary to set additional criteria for partial hospitalization services furnished by community mental health centers. *5-year savings: \$120 million (OACT estimate)*

Implementing the Competitive Bidding Demonstration for Durable Medical Equipment.

The OIG recently found that Medicare rates for hospital beds are substantially higher than rates paid by other payers. In January, HCFA will begin a competitive bidding demonstration using market forces to decrease Medicare payment for hospital beds and other durable medical equipment, thereby lowering program costs.

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**Comparing Drug Reimbursement:
Medicare and
Department of Veterans Affairs**



**JUNE GIBBS BROWN
Inspector General**

**NOVEMBER 1998
OEI-03-97-00293**

EXECUTIVE SUMMARY

PURPOSE

To compare Medicare allowances for prescription drugs with drug acquisition prices currently available to the Department of Veterans Affairs.

BACKGROUND

Medicare allowances for prescription drugs totaled almost \$2.3 billion in 1996. In 1997, allowances rose to approximately \$2.75 billion.

Medicare does not pay for over-the-counter or most outpatient prescription drugs. However, under specific circumstances, Medicare Part B covers drugs used with durable medical equipment or infusion devices. Medicare also covers certain drugs used in association with organ transplantation, dialysis, chemotherapy, and pain management for cancer treatment. Additionally, the program covers certain vaccines, such as those for influenza and hepatitis B.

Physicians and suppliers usually bill Medicare directly for the prescription drugs they provide to beneficiaries. Medicare Part B reimburses covered drugs at 95 percent of the drugs' average wholesale prices (AWPs). The beneficiary is responsible for a 20 percent coinsurance payment.

Unlike Medicare, the Department of Veterans Affairs (VA) purchases drugs for its healthcare system directly from manufacturers or wholesalers. There are several purchase options available to the VA, including the Federal Supply Schedule, Blanket Purchase Agreements, and VA national contracts.

We focused our inspection on 34 drug codes, each with over \$10 million in Medicare allowed charges for 1996. We then compared the amount Medicare reimbursed for those drugs to the VA's Federal Supply Schedule acquisition costs during the first quarter of 1998.

FINDINGS

Medicare and its beneficiaries could save \$1 billion in 1998 if the allowed amounts for 34 drugs were equal to prices obtained by the VA.

After comparing the median Medicare allowance with the corresponding median VA acquisition cost for 34 drugs, we estimated that Medicare and its beneficiaries could save \$1.03 billion in 1998 if the Medicare allowed amounts for 34 drugs were equal to prices obtained by the VA under the Federal Supply Schedule.

This savings represents almost half of the \$2.07 billion in reimbursement that Medicare and its beneficiaries paid for these 34 drugs in 1997. The estimated savings for individual drugs ranged from a high of \$276 million for J9217 (leuprolide acetate) to a low of \$16,460 for K0523 (concentrated metaproteranol sulfate).

Medicare allowed between 15 and 1600 percent more than the Department of Veterans Affairs paid for the 34 drugs reviewed.

The Medicare allowance was greater than the VA acquisition cost for every drug reviewed. For 3 of the 34 drugs, Medicare allowed more than 16 times the VA acquisition cost. Eleven drugs had Medicare allowances that were between two and six times higher than the VA cost. For only two drugs was the difference between Medicare reimbursement and VA cost less than 25 percent.

RECOMMENDATIONS

The Department of Veterans Affairs purchases drugs for its healthcare system directly from manufacturers or wholesalers. Conversely, Medicare reimburses doctors and suppliers for drugs which they administer or supply to beneficiaries. We recognize that the Health Care Financing Administration (HCFA) and the VA operate under different statutory constraints. Nevertheless, the fact remains that another Federal agency can get prescription drugs for a drastically lower price than Medicare.

Previous reports of the Office of Inspector General found that actual wholesale prices available to physicians and suppliers are often significantly lower than the Medicare allowed amounts. This report provides additional evidence that the published AWP's used in determining the Medicare allowed amounts for certain prescription drugs can be many times greater than the actual acquisition costs available in the marketplace.

We believe our current findings provide further support for recommendations made in earlier reports. We previously recommended that HCFA reexamine its Medicare drug reimbursement methodologies with the goal of reducing payments as appropriate. The HCFA concurred with this recommendation. We outlined a number of options for implementing this recommendation, including: (1) greater discounting of published average wholesale prices, (2) basing payment on acquisition costs, (3) establishing manufacturers' rebates similar to those used in the Medicaid program, and (4) using competitive bidding.

We continue to support the need for a comprehensive statutory reform of Medicare's prescription drug reimbursement methodology. A number of proposals addressing reform have been offered by both the Administration and members of Congress. However, until legislation can be enacted providing for such reform, we recommend that HCFA utilize the new inherent reasonableness or competitive bidding authorities provided in the Balanced Budget Act of 1997 to reduce Medicare's unreasonably high payments for certain drugs.

AGENCY COMMENTS

The HCFA concurred with our recommendations, stating that it appreciates the OIG's continuous efforts to assist it in obtaining the lowest prices for covered drugs. The HCFA noted that it has made several efforts to reduce excessive reimbursement rates, including using an inherent reasonableness adjustment for albuterol sulfate. The OIG supports these efforts and we believe HCFA should continue to use its inherent reasonableness authority to lower inappropriate payments for other drugs with excessive reimbursement rates.

**PRESIDENT CLINTON SENDS CONGRESS NEW PROPOSALS AND TAKES OTHER
STRONG STEPS TO FIGHT FRAUD AND ABUSE**

December 4, 1998

PROPOSED NEW LEGISLATIVE PACKAGE SAVING MEDICARE OVER \$2

BILLION OVER FIVE YEARS. The Administration is proposing a legislative package to combat fraud, abuse, and waste that will save Medicare over \$2 billion dollars over 5 years in the FY2000 budget. Highlights of this proposal include:

Eliminating Wasteful Excessive Medicare Reimbursement for Drugs. This proposal would eliminate the mark-up for drugs by basing Medicare's payment on the provider's actual acquisition cost of the drug. *5-year savings: \$690 million (OACT estimate)*

Eliminating Overpayments for Epogen. In a November 1997 report, the OIG found that the current EPO reimbursement rate of \$10 per 1,000 units exceeds the current cost of the drug by approximately \$1. This proposal reduces Medicare reimbursement to reflect current market prices. *5-year savings: \$320 million (OACT estimate)*

 **Ensuring Medicare does not Pay for Claims Owed by Private Insurers.** Medicare often pays claims owed by private insurers because it does not know that the beneficiary has other insurance which is responsible for the claim. These proposals require insurers to report the Medicare beneficiaries they insure to HCFA, permit Medicare to recoup twice the amount owed by insurers who purposely let Medicare pay claims that are the responsibility of the group plan, and impose fines for failing to report legal settlements for which Medicare should have been reimbursed. *5-year savings: \$690 million (OACT estimate)*

 **Eliminating Abuse of Medicare's Partial Hospitalization Benefit.** Providers often abuse Medicare's outpatient mental health benefits, billing for services in inpatient hospitals or homes. This proposal would require that these services are only provided in the appropriate treatment setting and authorize the Secretary to set additional criteria for partial hospitalization services furnished by community mental health centers. *5-year savings: \$120 million (OACT estimate)*

 **Implementing the Competitive Bidding Demonstration for Durable Medical Equipment.** The OIG recently found that Medicare rates for hospital beds are substantially higher than rates paid by other payers. In January, HCFA will begin a competitive bidding demonstration using market forces to decrease Medicare payment for hospital beds and other durable medical equipment, thereby lowering program costs.

TAKING NEW ACTIONS TO MAKE MEDICARE CONTRACTORS MORE ACCOUNTABLE FOR FIGHTING FRAUD.

Today, HCFA is also unveiling new steps they are taking to assure contractors are cracking down on fraud and abuse. They are:

Assuring Contractors Report Fraud Complaints to the Inspector General Right Away.

Currently, many contractors wait until they have hundreds of fraudulent claims before reporting them to the Inspector General. Starting next month, HCFA will send a program memorandum to every contractor requiring them to immediately refer fraud complaints to the Inspector General's office for review to ensure that fraudulent actions are identified and addressed expediently.

new specialized contractors for fraud.

Awarding First Contracts This Spring That Allows New Fraud Fighting Units to Perform Payment Safeguard Activities.

The Administration fought to include the Medicare Integrity Program (MIP) in the Health Insurance Portability and Accountability Act of 1996 that gave Medicare new authority to competitively contract with new fraud fighting units or "Medicare cops" that are better equipped to weed out fraud and abuse. Previously, carriers were contracting with the providers whose claims they processed, which gave them little incentive to detect fraudulent claims. This spring, the first fraud fighting units will begin their anti-fraud efforts.

Developing a Comprehensive Plan for Program Integrity. To improve efforts to cut down on fraud and abuse, HCFA is developing a new Comprehensive Plan for Program Integrity to be released in the spring. This report includes important new anti-fraud strategies including promoting appropriate reimbursement of legitimate providers for covered, reasonable, and necessary services provided to eligible beneficiaries. This comprehensive plan outlines a strategy to increase the effectiveness of current enforcement tools, expedite use of new authority to contract with fiscal intermediaries to perform payment safeguard activities, and instruct peer review organizations to examine program integrity and outside contractors to conduct cost report audits.

Asking Congress for New Contracting Authority to Enhance Contractor Performance.

HCFA does not currently have the authority to terminate contractors that do not meet basic performance standards without initiating a long, arduous performance review process -- during which the contractor is able to continue serving Medicare beneficiaries. The proposal would give HCFA new contracting flexibility that permits the agency to aggressively oversee general contractor performance, including important program integrity related functions, such as provider enrollment and overpayment collection.

Directing HCFA to Develop a Clearinghouse of Program Integrity Best Practices. In response to the Inspector General's recommendation that HCFA provide opportunities for Medicare contractors to exchange best practices relating the fraud and abuse detection, HCFA will also develop a clearinghouse for Medicare contractors to share effective procedures for identifying fraud and abuse. HCFA will also, for the first time, require contractors to develop specialized medical review policies to identify and address procedures which are widely overused and inappropriately prescribed. (*HHS -- OMB is recommending and we forgot to address on call. What do you think?*)

FAX TRANSMISSION

HEALTH CARE FINANCING ADMINISTRATION

7500 Security Boulevard
Baltimore, Maryland 21244
Fax: (410) 786-9188

To: Devora Adler

Date: 10/21/98

Fax #: 202-456-7431
202-456-5557

Pages: 1 (including cover sheet)]

From: Robin Fritter

Subject:

COMMENTS: # 410-786-7485

Comprehensive Plan for Program Integrity Executive Summary

As one part of our ongoing program integrity efforts, the Health Care Financing Administration (HCFA) sponsored a national conference on fraud, waste, and abuse in March 1998. This event brought together individuals from across industries and sectors, including key members of Congress, health care providers, representatives from the insurance industry, other private industries, and other government agencies, to talk about best practices and new strategies for confronting fraud and abuse. Many constructive lessons for fighting fraud and abuse resulted from the conference, many of which HCFA incorporates into its program integrity efforts.

To further our commitment to promoting the integrity of our programs, we are now leveraging the lessons learned from the March conference with our many existing Agency-wide program integrity activities. Through this marriage of existing activities and new ideas we have created a deliberate Comprehensive Plan outlining HCFA's overall program integrity strategy.

The following working draft of the Comprehensive Plan outlines HCFA's overall program integrity strategy. This plan includes:

- The Agency's program integrity goals;
- A brief description of current and ongoing program integrity activities;
- Key short-term initiatives for development and implementation; and
- A discussion about the resources necessary for HCFA to implement its program integrity strategy, including funding and technology.

The short-term initiatives include specific proposals to improve HCFA's management of program integrity activities, as well as proposals to address service specific program vulnerabilities. Our priorities are to:

- Increase the effectiveness of medical review and benefit integrity activities;
- Implement the Medicare Integrity Program;
- Implement payment safeguards for Balanced Budget Act provisions;
- Promote provider integrity;
- Initiate Millennium contingency planning; and,
- Address vulnerabilities in inpatient hospital care, congregational care, and managed care.

We are sharing this plan with our internal and external partners and welcome your comments so that this plan is viable, effective, and developed in a collaborative spirit. We intend to finalize the plan and submit it to Congress with the Fiscal Year (FY) 2000 Budget (subject to review by the Office of Management and Budget).

NOTE TO: Jose, Leanne, Chris, Jeanne, Devorah

FROM: Cynthia Rice

RE: Possible Additional Elder Crime Initiative

FYI -- You might be able to add this initiative to the elder crime initiatives you are working on.
I'll tell Leg Affairs this doesn't need a response from us.

LORETTA SANCHEZ

46TH DISTRICT, CALIFORNIA

COMMITTEE ON
EDUCATION AND THE WORKFORCE

SUBCOMMITTEES:

POST-SECONDARY EDUCATION
OVERSIGHT AND INVESTIGATIONS

COMMITTEE ON NATIONAL SECURITY

SUBCOMMITTEE:

MILITARY RESEARCH AND DEVELOPMENT

December 11, 1997



Congress of the United States

House of Representatives

Washington, DC 20515-0546

REPLY TO:

☐ WASHINGTON OFFICE

1529 LONGWORTH BUILDING
WASHINGTON, DC 20515-0546
(202) 225-2965

☐ DISTRICT OFFICE

12397 LEWIS STREET, SUITE 101
GARDEN GROVE, CA 92840-4695
(714) 621-0102

President William Jefferson Clinton
1600 Pennsylvania Ave.
Washington, D.C. 20500

DEC 17 1997

Dear President Clinton:

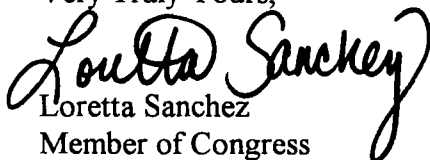
I am writing this letter to respectfully request your support and recommendation of H.R. 2964, "The Older and Disabled Americans Protection Act of 1997". Many seniors want their well-deserved independence during the later years of their lives and as a result enter into shared housing agreements. These arrangements are non-fee, home-finder referral services that match seniors or the disabled with others who wish to share a house, apartment, or mobile home at affordable rates.

Unfortunately, senior citizens are all too often being manipulated and abused within the privacy of their own homes. Abuse in shared housing arrangements is on the rise. A recent article in the *Orange County Register* noted that 4 to 10 percent of Orange County's 350,000 seniors are victims of some sort of abuse. These numbers ring true throughout the county, where abuse reports have risen to 2,173 in 1995 from a low of 903 in 1987. Most of these cases of abuse are either physical or financial. Unfortunately, many more cases often go unreported due to shame and reluctance to report the abuse on the part of the victims.

Under current federal law there does not exist a national or a statewide standard procedure that is available to screen shared housing participants. As a consequence, I introduced H.R. 2964, "The Older Americans and Disabled Act of 1997" which would empower placement organizations with the authority to run FBI background checks on potential shared housing participants. These checks would give these organizations the ability to protect their clients from abuse by known criminals.

Similar laws already exist to allow for background checks of nursing home employees, child care providers, school bus drivers, and security guards. It is now only logical to extend this provision to protect seniors in their own homes. I have attached a copy of the bill for your information. I respectfully request your support and endorsement. Thank you for your attention to this matter.

Very Truly Yours,


Loretta Sanchez
Member of Congress

Older and Disabled Americans Protection Act of 1997 (Introduced in the House)

HR 2964 IH

105th CONGRESS

1st Session

H. R. 2964

To provide for reviews of criminal records of applicants for participation in shared housing arrangements, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

November 8, 1997

Ms. SANCHEZ (for herself, Mr. TORRES, Mr. MARTINEZ, and Mr. SNYDER) introduced the following bill; which was referred to the Committee on the Judiciary

A BILL

To provide for reviews of criminal records of applicants for participation in shared housing arrangements, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the 'Older and Disabled Americans Protection Act of 1997'.

SEC. 2. BACKGROUND CHECKS.

(a) IN GENERAL- A shared housing referral service, as determined for the purpose of this section by the Attorney General, may request the Attorney General to conduct a search and exchange of records under subsection (b) regarding any applicant for participation in a shared housing arrangement as a service provider resident by--

(1) submitting, to the Attorney General--

(A) fingerprints (or another form of positive identification approved by the Attorney General) regarding such applicant; and

(B) a written statement authorizing the shared housing referral service to request the search and exchange of records regarding the applicant, which is signed by the applicant; and

(2) making the submission of the information under paragraph (1) not more than 1 day (not including Saturdays, Sundays, and legal public holidays under section 6103 of title 5, United States Code) after completing acquiring the information.

(b) **SEARCH AND EXCHANGE OF RECORDS-** Pursuant to any submission that complies with subsection (a), the Attorney General shall search the records of the Criminal Justice Information Services Division of the Federal Bureau of Investigation for any criminal history records corresponding to the fingerprints or other positive identification submitted. The Attorney General shall provide any corresponding information identified by the search to the appropriate State or local governmental agency authorized to receive such information.

(c) **USE OF INFORMATION-** Information regarding any applicant for participation in a shared housing arrangement obtained pursuant to subsection (b) may be used only by the shared housing referral service requesting the information and only for determining the suitability of the applicant for participation in a shared housing arrangement as a service provider resident.

(d) **FEES-** The Attorney General may charge a reasonable fee, which may not exceed \$50, to any shared housing referral service requesting a search and exchange of records pursuant to subsection (b) to cover the costs of conducting the search and providing the records.

(e) **REPORT-** The Attorney General shall submit a report to the House of Representatives and the Senate not later than 2 years after the date of enactment of this Act regarding the number of requests for searches and exchanges of records made under this section by shared housing referral services and the disposition of such requests.

SEC. 3. CRIMINAL PENALTY.

Whoever knowingly uses any information obtained pursuant to section 2(b) in violation of section 2(c) shall be fined under title 18, United States Code, or imprisoned for not more than 2 years, or both.

SEC. 4. ORGANIZATIONAL LIABILITY.

A shared housing referral agency that, in making a determination regarding any referral for participation in a shared housing arrangement, reasonably relies upon information provided to the agency by the Attorney General pursuant to section 2 shall not be liable, in any action for damages based on the referral determination, for any damages resulting from incompleteness or inaccuracy of the information.

SEC. 5. DEFINITIONS.

For purposes of this Act, the following definitions shall apply:

(1) **SHARED HOUSING ARRANGEMENT-** The term 'shared housing arrangement' means a primary residential arrangement that consists of at least 2 persons--

(A) who reside in the same dwelling unit and share the use of all or part of the facilities of the dwelling unit;

(B) who have no familial relationship;

(C) one of whom is an elderly person or a person with disabilities, who owns or is the lessee of the dwelling unit; and

(D) another of whom who provides care or other services for the benefit of the person described in subparagraph (C) in exchange for free occupancy in the dwelling unit, a reduction in the cost otherwise charged for occupancy of the

dwelling unit, or other remuneration.

(2) **SHARED HOUSING REFERRAL SERVICE-** The term 'shared housing referral service' means any nonprofit or for-profit organization, person, or other entity that, for consideration, performs services which involve the referral of individuals or families for participation in shared housing arrangements as service provider residents.

(3) **SERVICE PROVIDER RESIDENT-** The term 'service provider resident' means, with respect to a shared housing arrangement, the individual participating in the arrangement who is described in paragraph (1)(D).

(4) **ELDERLY PERSON; PERSON WITH DISABILITIES-** The terms 'elderly person' and 'person with disabilities' have the meanings given such terms in section 3(b) of the United States Housing Act of 1937.

SEC. 6. REGULATIONS.

The Attorney General may prescribe any regulations necessary to carry out this Act, including regulations regarding the security, confidentiality, accuracy, use, and dissemination of information and audits and recordkeeping and the imposition of fees necessary for the recovery of costs.

DRAFT -- 9 a.m. December 7

Remarks by
Nancy-Ann Min DeParle, Administrator*
Health Care Financing Administration

Event on Waste, Fraud and Abuse
White House
Washington, D.C.

December 7, 1998

* This text serves as the basis for the Administrator's oral remarks and should be used with the understanding that material may be added or omitted at the time of presentation.

Good afternoon. I'm Nancy-Ann DeParle, and I am Administrator of the Health Care Financing Administration.

I have been privileged to be a part of President Clinton's Administration since 1993, first at the Office of Management and Budget, and since November of last year, as head of the Department of Health and Human Services agency that is responsible for making sure more than 38 million Americans get Medicare benefits.

Since its creation more than 30 years ago, Medicare has forever changed what it means to grow old in America. I'm reminded of this every time I talk to senior citizens and their families. Last December, I spent an afternoon visiting the Marconi Senior Citizens' Club in South Philadelphia. One woman stood up and asked me to bring a message back to the President.

Mr. President, she said, "When you see President Clinton, tell him I said thank you for protecting Medicare." She said, "My parents had nothing, but I don't have to worry because I have

Medicare.”

Because there are millions of Americans like her, President Clinton has been fighting hard for Medicare since he took office. His administration has done more to fight fraud, waste and abuse in Medicare than any other. No one has been more committed to this effort than President Clinton and two people who couldn't be with us today, Vice President Gore and Secretary Shalala.

Let me add that our thoughts and prayers are with the Gore family. Senator Gore Sr. was my senator. For many Tennesseans my age, he was the one who inspired us to enter public service, so I honor and salute him today.

And I can't say enough about Secretary Shalala for her leadership at HHS to protect Medicare for our parents and grandparents and for our children and grandchildren.

The fight to protect Medicare from ripoff artists and

unscrupulous providers has been a joint effort. It involves many fronts and many partners, in particular my colleague June Gibbs Brown, the HHS Inspector General [who is here today]; the Justice Department [anyone to recognize?]; the FBI; state and local authorities; and private businesses.

Together, we are protecting and strengthening Medicare, tightening requirements and toughening standards. Last year alone, our efforts saved Medicare \$7.5 billion and returned another \$1 billion to the Trust Fund. Our cooperative effort known as Operation Restore Trust produced a 23-to-1 return in Medicare savings.

Congress has been a key partner, passing laws and providing the resources that help us fight fraud, waste and abuse and ensure that Medicare is billed correctly for providing beneficiaries with the care to which they're entitled.

And I'm grateful for the bipartisan efforts in Congress to stop

those who rob from our beneficiaries and taxpayers. Senator Tom Harkin has been a leader in Congress and a true friend of Medicare beneficiaries. I appreciate his hard work to make sure we have the tools we need in this fight. And I'm glad he is with us today.

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1998 03/14 HCFH PRESS OFFICE 202 696 7159 P.02/06

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#

TO CHRIS JENNINGS
456-5557
FROM CHRIS PEACOCK
690-6145

THIS UPDATES VERSION SENT
AT 9 A.M. TODAY.

DRAFT -- 10 a.m. December 7

Remarks by
Nancy-Ann DeParle, Administrator*
Health Care Financing Administration

Event on Waste, Fraud and Abuse
White House
Washington, D.C.

December 7, 1998

Mike
Mangano
will
attend
rather
than
June
Gibbs Brown

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TO CHRIS JENNINGS
426 5557
FROM CHRIS PEACOCK
690-6145

THIS UPDATES VERSION SENT
AT 9 A.M. TODAY.

DRAFT -- 10 a.m. December 7

Remarks by
Nancy-Ann DeParle, Administrator*
Health Care Financing Administration

Event on Waste, Fraud and Abuse
White House
Washington, D.C.

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#



From the office of:
Congressman Pete Stark
13th District, California

239 Cannon House Office Building
Washington, D.C. 20515
Phone: (202) 225-5065 Fax: (202) 226-3805

To: Chris Jennings 456-5557

From: Debbie Curtis

Number of pages following this cover: 8

If you have any problems or questions, please call the sender at the number above.

Comments:

We're going to introduce this later in January + wanted to run it by you since you've talked about similar proposals. I'm sending it to Jane Horvath & Bonnie Washington too.

JANUARY 4, 1999

106TH CONGRESS
1ST SESSION**H. R. _____**

IN THE HOUSE OF REPRESENTATIVES

Mr. STARK introduced the following bill; which was referred to the Committee
on _____

A BILL

To amend title XVIII of the Social Security Act to combat fraud and abuse under the medicare program with respect to partial hospitalization services.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the "Partial Hospitalization
5 Services Integrity Act of 1999".

1 **SEC. 2. LIMITATION ON LOCATION OF PROVISION OF SERV-**
2 **ICES.**

3 (a) IN GENERAL.—Section 1861(ff)(2) of the Social
4 Security Act (42 U.S.C. 1395x(ff)(2)) is amended in the
5 matter following subparagraph (I)—

6 (1) by striking “and furnished” and inserting
7 “furnished”; and

8 (2) by inserting before the period the following:
9 “, and furnished other than in a skilled nursing fa-
10 cility or in an individual’s home”.

11 (b) EFFECTIVE DATE.—The amendments made by
12 subsection (a) apply with respect to partial hospitalization
13 services furnished on or after the first day of the third
14 month beginning after the date of the enactment of this
15 Act.

16 **SEC. 3. QUALIFICATIONS FOR COMMUNITY MENTAL**
17 **HEALTH CENTERS.**

18 (a) IN GENERAL.—Section 1861(ff)(3)(B) of the So-
19 cial Security Act (42 U.S.C. 1395x(ff)(3)(B)) is amended
20 by striking “entity” and all that follows and inserting the
21 following: “entity that—

22 “(i)(I) provides the mental health services de-
23 scribed in section 1913(c)(1) of the Public Health
24 Service Act; or

✓ 25 ~~review~~ “(II) in the case of an entity operat-
26 ing in a State that by law precludes the entity from

1 providing a service described in such section itself,
2 provides for such service by contract with an ap-
3 proved organization or entity (as determined by the
4 Secretary);

5 “(ii) meets applicable licensing or certification
6 requirements for community mental health centers
7 in the State in which it is located;

8 “(iii) provides a significant share of its services
9 (as determined by the Secretary) to individuals who
10 are not eligible for benefits under this title; and

11 “(iv) meets such additional conditions as the
12 Secretary shall specify to ensure (I) the health and
13 safety of individuals being furnished such services,
14 (II) the effective or efficient furnishing of such serv-
15 ices, and (III) the compliance of such entity with the
16 criteria described in such section.”.

✓ 17 ~~Review~~ (b) EFFECTIVE DATE.—The amendment
18 made by subsection (a) applies with respect to community
19 mental health centers furnishing services under the medi-
20 care program on or after the first day of the third month
21 beginning after the date of the enactment of this Act.

22 **SEC. 4. REFINEMENT OF PERIODICITY OF REVIEW OF PLAN**
23 **FOR PARTIAL HOSPITALIZATION SERVICES.**

24 (a) IN GENERAL.—Section 1835(a)(2)(F)(ii) of the
25 Social Security Act (42 U.S.C. 1395n(a)(2)(F)(ii)) is

1 amended by inserting "~~monthly~~ [at a reasonable rate ✓
2 (as determined by the Secretary)]" after "is reviewed pe-
3 riodically". ~~Question: doesn't the Secretary by regula-~~
4 ~~tions have requirements of periodicity or is it left up to~~ ✓
5 ~~the physicians?~~ ✓

6 ~~Review~~ (b) EFFECTIVE DATE.—The amendment
7 made by subsection (a) applies with respect to plans for
8 furnishing partial hospitalization services established on or
9 after the first day of the third month beginning after the
10 date of the enactment of this Act.

11 **SEC. 5. AUDIT OF PROVIDERS OF PARTIAL HOSPITALIZA-**
12 **TION SERVICES.**

13 (a) IN GENERAL.—With respect to each hospital and
14 each community mental health center that furnishes par-
15 tial hospitalization services for which payment is made
16 under title XVIII of the Social Security Act, the Secretary
17 of Health and Human Services shall provide for periodic
18 audits to ensure that the provision of such services com-
19 plies with applicable requirements of such title.

20 (b) DEADLINE FOR FIRST AUDIT.—The first audit
21 under subsection (a) shall be completed not later than 1
22 year after the date of the enactment of this Act.

1 **SEC. 6. CIVIL MONETARY PENALTIES FOR FALSE CERTIFI-**
2 **CATION OF ELIGIBILITY FOR HOSPICE CARE**
3 **OR PARTIAL HOSPITALIZATION SERVICES.**

4 (a) IN GENERAL.—Section 1128A(b)(3) of the Social
5 Security Act (42 U.S.C. 1320a-7a(b)(3)) is amended—

6 (1) in subparagraph (A)(ii), by inserting “, hos-
7 pice care, or partial hospitalization services” after
8 “home health services”; and

9 (2) in subparagraph (B), by inserting “, section
10 1814(a)(7) in the case of hospice care, or section
11 1835(a)(2)(F) in the case of partial hospitalization
12 services” after “in the case of home health services”.

13 ~~Review~~ (b) EFFECTIVE DATE.—The amendments
14 made by subsection (a) apply with respect to certifications
15 of eligibility for hospice care or partial hospitalization
16 services under the medicare program made on or after the
17 first day of the third month beginning after the date of
18 the enactment of this Act.

19 **SEC. 7. DEMONSTRATION FOR EXPANDED PARTIAL HOS-**
20 **PITALIZATION SERVICES.**

21 (a) ESTABLISHMENT.—

22 (1) IN GENERAL.—The Secretary of Health and
23 Human Services shall implement a demonstration
24 project (in this section referred to as the “project”)
25 under part B of title XVIII of the Social Security
26 Act under which community mental health centers

1 may offer expanded partial hospitalization services
2 (described in paragraph (2)) for purposes of provid-
3 ing for a full continuum of ambulatory behavioral
4 health care services.

5 (2) ADDITIONAL MENTAL HEALTH SERVICES
6 DESCRIBED.—For purposes of paragraph (1), the
7 expanded partial hospitalization services are out-
8 patient mental health services and such other mental
9 health services as the Secretary determines appro-
10 priate which are not partial hospitalization services
11 as defined in section 1861(ff)(1) of such Act (42
12 U.S.C. 1395x(ff)(1)).

13 (b) SELECTION OF CENTERS.—For purposes of im-
14 plementing such project, the Secretary shall select for par-
15 ticipation in the project community mental health centers
16 that serve populations in 3 different States, 1 of which
17 predominantly serves rural populations.

18 (c) CAPITATED PAYMENT.—Under this project, pay-
19 ment for expanded partial hospitalization services shall be
20 made on a capitated basis.

21 (d) WAIVER AUTHORITY.—The Secretary may waive
22 such provisions of title XVIII of the Social Security Act
23 as the Secretary deems necessary to conduct the project
24 established under this section.

25 (e) EVALUATION AND REPORT.—

1 (1) EVALUATION.—The Secretary shall evaluate
2 the project. Such evaluation shall include an exam-
3 ination of—

4 (A) the project's effect on the ~~health and~~^{INDIVIDUAL'S HEALTH,}
5 well-being ~~of beneficiaries;~~^{FUNCTIONAL LEVEL, AND}

6 (B) any savings to the medicare program
7 by reason of capitated payments for partial hos-
8 pitalization services;

9 (C) the impact of basing payment for such
10 services on a capitated basis; and

11 (D) the project's effect on utilization of in-
12 patient services (including inpatient mental
13 health services) and associated costs.

14 (2) REPORT.—Not later than 4 years after the
15 date of the enactment of this Act, the Secretary
16 shall submit to Congress a report containing a state-
17 ment of the findings and conclusions of the Sec-
18 retary pursuant to the evaluation conducted under
19 paragraph (1), together with any recommendations
20 for legislation the Secretary considers appropriate
21 with respect to—

22 (A) the provision of additional mental
23 health services by community mental health
24 centers under partial hospitalization services;
25 and

1 (B) payment for such services on a
2 capitated basis.

3 (f) DURATION.—The project shall be conducted for
4 a 3 year period.



U.S. Department of Justice

Office of the Deputy Attorney General

Washington, D.C. 20530

FAX TRANSMISSION SHEET

TO:

Chris Jennings

Phone: _____

Fax: 456-5557

FROM:

John T. Bentivoglio

Special Counsel for Health Care Fraud

Phone: (202) 514-2707

Fax: (202) 616-1239

DATE:

3-12-99

NUMBER OF PAGES (including this cover sheet): _____

MESSAGE:

FYI

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

**U.S. Department of Justice**

Office of the Deputy Attorney General

*Special Counsel for Health Care Fraud**Washington, D.C. 20530*

March 12, 1999

VIA FACSIMILE

Mike Hash
Deputy Administrator
Health Care Financing Administration
200 Independence Avenue, NW
Washington, DC 20201

Dear Mike:

Thank you for meeting with us today regarding various nursing home matters, including the Department's proposed nursing home legislation. We appreciate the concerns of the Department of Health and Human Services discussed at today's meeting and are hopeful that the compromises and suggestions we made at today's meeting adequately address these concerns. We continue to believe there is a serious gap in current law with respect to criminal and civil enforcement authority and want to craft legislation that is as effective as possible.

On the attached page, I have attempted to capture the suggestions we offered at today's meeting, along with several background items that help explain our positions.

I look forward to resolving these issues as quickly as possible

Sincerely,

A handwritten signature in dark ink, appearing to read "John T. Bentivoglio", with a stylized flourish at the end.

John T. Bentivoglio

cc: D. McCarthy Thornton
Chief Counsel
HHS Office of Inspector General

Comments and Suggestions on DOJ's Proposed Nursing Home Legislation

- The Department of Justice (DOJ) agrees with the Department of Health and Human Services (HHS) that HCFA needs new administrative authority to address quality of care problems involving nursing home chains and management companies and DOJ would be willing to support new authority for HCFA in this area.
- To address concerns about adequate communication and consultation between DOJ and HHS, the DOJ suggests adding the following language to the end of the legislation:

“Within 90 days of enactment of this section, the Attorney General and the Secretary of Health and Human Services shall enter into a Memorandum of Understanding to ensure adequate communication and coordination of enforcement actions initiated under this section.”

Notes:

1. This requirement would ensure that DOJ and HHS establish appropriate procedures and lines of communication with respect to nursing home enforcement activities. The MOU would require full concurrence from the Secretary of HHS.
 2. Under HIPAA, the Attorney General and Secretary of HHS were required to establish guidelines governing virtually every major aspect of the DOJ-HHS fraud-fighting relationship. These guidelines, which are approximately 25 pages, were completed within approximately 130 days (HIPAA was signed into law on August 21, 1996 and the guidelines were complete on or about January 1, 1997). Surely, guidelines addressing nursing home enforcement actions could be developed in 90 days after the date of enactment (particularly since there are on-going negotiations over a revised nursing home MOU).
- To address the particular concerns about the injunctive relief provisions in the legislation, DOJ will commit to include -- in the MOU implementing this legislation -- a requirement of advance consultation with program agency officials in advance of any request for injunctive relief. In addition, DOJ would be willing to discuss appropriate dispute resolution mechanisms in the event of a disagreements (such as reiterating the present requirement that a decision to take legal action over the objection of a client agency requires approval from an official in Main DOJ).

Notes:

1. DOJ has had authority to enforce the Civil Rights of Institutionalized Persons Act (CRIPA) for more than 20 years. CRIPA authorizes DOJ to obtain injunctive relief against publicly operated facilities that violate constitutional or statutory protections of institutionalized persons (including cases involving publicly

operated nursing homes). The only relief available under CRIPA is injunctive relief. During this 20 year period, DOJ officials regularly have consulted with HCFA about actions brought under CRIPA and we are aware of no serious problems. While there are differences between the nursing home legislation and CRIPA, DOJ's track record under CRIPA should provide some comfort that adequate communication and coordination can be achieved.

- DOJ agrees with HHS that we need to spell out the definition of "harm" in the statute to ensure consistency with regulatory definitions and the like.
- With regard to the definition of "pattern" of violations, we agree with the comments of the HHS OIG that the current definition may be subjective and unwieldy. HHS OIG suggested a change to a numerical number of violations. This approach would provide greater clarity to the statute and make it a more effective enforcement tool. DOJ suggests that the current draft would be substantially improved if it were amended to delete the reference to pattern and insert "three or more" violations.

Notes:

1. Although moving from the term "pattern" to a numerical threshold of three violations would lessen the burden on the government, DOJ suggests retaining the requirement (spelled out in the current definition of pattern) that the three violations would still need to be linked in some way – i.e., that they are repeated, systemic, result from a common policy or practice, or the like. Even under a numerical threshold, the statute would be limited to the most egregious cases.
- 2.

HCFA comments on proposed nursing home legislation -

Include in the statute:

1. A requirement that an MOU have been agreed to before any enforcement under the statute.
2. "Nothing in this Act shall be construed as depriving the Secretary of Health and Human Services of any authority, including enforcement authorities, under the Social Security Act related to nursing homes."
3. No civil or injunctive action may be brought without having been referred by the Secretary of Health and Human Services.

The MOU should:

1. Key definitions of terms such as "harm," "pattern" and "widespread" should be consistent with HCFA definitions.
2. Specify procedures for cases that do not originate in HHS being reviewed by IHHS and referred to DOJ.

CR IPA authority
20 years example of no problems in
this area — only injunctive authority —
that's where there's the greatest overlap

mtg next week
Elena
Dan
Jose
Wanda
NAMB
Mike
John

|| FRAUD LEAK ||

Tobacco Bill —
Mike being hung
out to dry on tobacco



U.S. Department of Justice

Office of the Deputy Attorney General

1-11-99

Washington, D.C. 20530

FAX TRANSMISSION SHEET

TO: Chris Jennings

Phone: 456-5560 Fax: 456-5557

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Special Counsel for Health Care Fraud

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DATE: 1/11/99

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MESSAGE: _____

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U.S. Department of Justice

Office of the Deputy Attorney General

Special Counsel for Health Care Fraud

Washington, D.C. 20530

January 11, 1999

To: Chris Jennings
From: John T. Bentivoglio *JTB*
Subj: Legislative proposals

As you probably know, the Department of Justice is working with the Domestic Policy Council on a major crime legislative package, which is scheduled for introduction in the early days of the 106th Congress. I wanted to make sure you are aware of several proposals that we would like to include in the area of health care fraud.

Specifically, we would like to revisit several legislative proposals that were circulated and discussed last year but that never received sufficient support to warrant sending them to OMB for formal interagency comments. I have the proposed legislative language and section by section analysis for five separate proposals. These are the same proposals that we circulated last year but generated opposition from Main HHS.

While I know you may have some hesitation, I believe we can make a persuasive case on the merits for these proposals. I also think the environment in Congress will be a little more favorable this year, although I do not underestimate the difficulty we will have in getting these passed.

If you have any questions, please call me at (202) 514-2707.

SEC. _____. GRAND JURY DISCLOSURE.

Section 3322 of title 18, United States Code, is amended –

(1) by redesignating subsections (c) and (d) as subsections (d) and (e),
respectively; and

(2) by inserting after subsection (b) the following new subsection:

“(c) A person who is privy to grand jury information concerning a
Federal health care offense, as defined in section 24 of this title –

“(1) received in the course of duty as an attorney for the
government; or

“(2) disclosed under rule 6(e)(3)(A)(ii) of the Federal Rules
of Criminal Procedure;

may disclose that information to an attorney for the government to use in
any investigation or civil proceeding relating to health care fraud.”.

SEC. _____. AUTHORIZED INVESTIGATIVE DEMAND PROCEDURES.

Subsection (a) of section 3486 of title 18, United States Code, is amended by
inserting after “Federal health care offense”, “,or any allegation of health care fraud
(whether criminal or civil),”.

SEC. ____ . ATTORNEY GENERAL'S INJUNCTION AUTHORITY.

Section 1128B of the Social Security Act (42 U.S.C. § 1320a-7b) is amended by adding the following new subsection –

“(h) If the Attorney General has reason to believe that a person is engaging about to engage in conduct constituting an offense under this section, the Attorney General may petition an appropriate United States District Court for an order prohibiting that person from engaging in such conduct. The court may issue an order prohibiting that person from engaging in such conduct if the court finds that the conduct constitutes such an offense. The filing of a petition under this section does not preclude any other remedy that is available by law to the United States or any other person.”.

SEC. ____ . ATTORNEY GENERAL'S AUTHORITY TO SEEK CIVIL PENALTIES.

Section 1128B(b) of the Social Security Act (42 U.S.C. § 1320a-7b(b)) is further amended by adding the following new subsection –

“(g)(1) The Attorney General may bring an action in the district courts to impose upon any person who carries out any activity in violation of this section with respect to a Federal health care program a civil penalty of \$25,000 to \$50,000 for each such violation, and damages of three times the total remuneration offered, paid, solicited, or received.

“(2) A violation exists under paragraph (1) if one or more purposes of the remuneration is unlawful, and the damages shall be the full amount of such remuneration.

“(3) The procedures for actions under paragraph (1) with regard to subpoenas, statutes of limitation, standards of proof, and collateral estoppel shall be governed by 31 U.S.C. § 3731, and the Federal Rules of Civil Procedure shall apply to actions brought under this section.

“(4) This section does not affect the availability of other criminal and civil remedies that may be available for such violations.”.

SEC. ____ . EXTENSION OF CRIMINAL PENALTIES FOR KICKBACKS

Section 1128B of the Social Security Act (42 U.S.C. § 1320a-7b) is amended by striking “Federal health care program” each place it appears and inserting in lieu thereof “health care benefit program (as defined in 18 U.S.C. § 24(b))”.

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SECTION-BY-SECTION ANALYSIS

Section . GRAND JURY DISCLOSURE.

Under existing law, an attorney for the government may not, as a general matter, disclose matters that occur before a Federal grand jury. A violation of this non-disclosure requirement (set forth in Rules 6(e) of the Federal Rules of Criminal Procedure) is punishable as contempt of court. An overriding objective of this prohibition is to protect the integrity of criminal investigations by limiting opportunities to intimidate witnesses, destroy documents or otherwise obstruct justice. The prohibition is also important in protecting the rights and reputations of persons who appear before grand juries.

In 1989, Congress created an exception to Rule 6(e) when it enacted 18 U.S.C. § 3322 ("Disclosure of Certain Matters Occurring Before Grand Jury") (enacted as section 964 of the "Financial Institutions Reform, Recovery, and Enforcement Act of 1989," (Pub. L. 101-73). Under 18 U.S.C. § 3322(a), an attorney for the government who is privy to grand jury information involving a criminal violation of the Federal banking laws may disclose that information to another attorney for the government for use in connection with civil actions commenced to enforce the banking laws. In enacting this provision, Congress recognized that, in this important class of cases, in which both criminal and civil actions are routinely brought against wrongdoers, and in which large amounts of money are at stake, the Rule 6(e) restriction on disclosure needlessly complicated investigations in complex financial institution fraud cases.

The draft bill would merely extend the existing Rule 6(e) exception to Federal health care offenses, as defined in 18 U.S.C. § 24. Enactment of this provision would not make available information to civil prosecutors that is not already available to them. Rather, it would simplify information sharing and would enhance the government's ability to investigate wrongdoing. Such a provision would be very important for the effectiveness of our overall health care anti-fraud effort. In particular, by facilitating the sharing of information between criminal investigators and civil prosecutors, this proposal would enable us to proceed more quickly and efficiently to recover losses to federal health care programs, such as Medicare, Medicaid, CHAMPUS, and the Federal Employee Health Benefit Program and to prevent wrongdoers from dissipating illegally obtained assets before we can take action to recover the government's losses.

SEC. ____ .AUTHORIZED INVESTIGATIVE DEMAND PROCEDURES.

Under section 248 of the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191) (enacting new 18 U.S.C. § 3486), the Attorney General or her designee is authorized to issue an administrative subpoena in connection with an

investigation relating to a "Federal health care offense." Under 18 U.S.C. § 24, a "Federal health care offense" is defined to include only criminal offenses. In civil cases, however, the Department's attorneys must rely on subpoenas issued by the Office of the Inspector General (OIG) of the Department of Health and Human Services (which are issued only to OIG agents assigned to a particular case) or upon civil investigative demands (which must be signed personally by the Attorney General). This constitutes a serious limitation on our ability to investigate civil health care fraud cases in an effective and efficient manner. As a consequence, this provision would make it clear that the Attorney General or her designee (e.g., a duly authorized Assistant United States Attorney) would be permitted to issue an administrative subpoena in connection with any health care fraud case, criminal or civil, thus greatly facilitating our ability to pursue wrongdoers.

SEC. ____ . ATTORNEY GENERAL'S INJUNCTION AUTHORITY.

Under existing law (18 U.S.C. § 1345(a)(1)(C)), Federal prosecutors are able to obtain injunctive relief in connection with a wide variety of Federal health care offenses. This authority has proven to be extremely valuable in putting a halt to fraudulent behavior. Unfortunately, however, such relief is not available in connection with kickback offenses under section 1128B of the Social Security Act (42 U.S.C. § 1320a-7b) ("Criminal penalties for acts involving Medicare or State health care programs"). This is a serious omission. Because of the large amounts of money involved in these kinds of cases, it is essential that we have the authority to enjoin kickback schemes while they are in progress. The draft bill would permit us to do so.

SEC. ____ . ATTORNEY GENERAL'S AUTHORITY TO SEEK CIVIL PENALTIES.

Section 1128B of the Social Security Act (42 U.S.C. § 1320a-7b) establishes criminal penalties for kickback offenses committed against federal health care programs, such as Medicare and CHAMPUS. There is, however, no direct civil penalty applicable to such offenses. As a consequence, an attorney for the government is forced in cases of this nature to do nothing or pursuing criminal charges – quite possibly in a case that, while meriting government action, might not be appropriate for criminal prosecution. The draft bill would permit the Attorney General to bring civil actions against wrongdoers under the anti-kickback provisions of the Social Security Act. Civil penalties are, in our view, particularly important in the health care fraud, since the complex business arrangements that are often employed in connection with kickback schemes often make it difficult – or impossible – to demonstrate the necessary scienter needed to sustain a criminal prosecution.

SEC. ____ . EXTENSION OF CRIMINAL PENALTIES FOR KICKBACKS.

Under current law (section 1128B(b) of the Social Security Act, 42 U.S.C. § 1320a-7b(b)), the anti-kickback provisions apply only to health care plans receiving federal funds, such as Medicare, Medicaid, and CHAMPUS. We are not aware of any justification for limiting sanctions against illegal kickbacks to Federal health care programs. Kickback schemes committed in connection with private health insurance plans result in the loss of millions of dollars each year and are contrary to the best interests of patients and the public. We believe that we should be able to proceed criminally against kickbacks committed against either public or private health plans, and this provision would provide us with the authority to do so.

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