

ANTI-FRAUD, WASTE AND ABUSE LEGISLATIVE PROPOSALS FROM HCFA

Provider Accountability

- o **Sanction Authority** - This proposal would improve our ability to levy penalties on and sanction fraudulent providers.

First, this proposal would create a new civil monetary penalty for physicians who certify that an individual meets Medicare requirements to receive partial hospitalization and hospice services while knowing that the individual does not meet such requirements.

Second, this proposal would correct the statutory oversight which failed to specify a dollar amount for civil money penalties that may be imposed upon: nonparticipating physicians who bill more than the limiting charge; providers who bill for clinical diagnostic laboratory tests; physicians who bill on an unassigned basis for services rendered to dually eligible beneficiaries; nonparticipating physicians who fail to notify beneficiaries of the actual charge of elective surgery; suppliers who fail to supply DME without charge after all the rental payments have been made; nonparticipating radiologists who bill more than the limiting charge; nonparticipating physicians who bill more than the limiting charge for mammographies; physicians that bill for assistants at cataract surgery; nonparticipating physicians who do not make refunds to beneficiaries for medically unnecessary and/or poor quality of care services; physicians who repeatedly bill beneficiaries for certain diagnostic tests in excess of the limiting charge; nonparticipating physicians and/or suppliers that bill in excess of the limiting charge.

Third, this proposal would authorize civil money penalties to be levied on providers that violated the anti-kickback statute.

Fourth, this proposal would authorize civil money penalties against anyone who knows or should know that they are submitting claims for services ordered or prescribed by an excluded individual.

Fifth, this proposal would allow civil money penalties to be levied on hospitals or other providers who hire excluded individuals.

Sixth, this proposal would extend the testimonial subpoena power and injunctive authority that the Secretary has for civil money penalties to other administrative sanctions such as exclusions.

Seventh, this proposal would overrule the Hanlester decision, such that the government need not prove that perpetrating providers had actual knowledge of the anti-kickback laws.

Finally, this proposal would clarify that under the anti-dumping statute, physicians who are on-call to speciality hospitals must respond to a call from the hospital to come in to the specialty unit (e.g. a burn center) in order to examine and stabilize the emergency medical condition of an individual who is proposed to be transferred to that unit.

Rationale: This proposal would provide the authority to further protect beneficiaries, Medicare and Medicaid.

This provision (which parallels the authority created in HIPAA for false certification of home health services) by penalizing physicians for inappropriate admissions to partial hospitalization programs, would create a real incentive for physicians to certify need for partial hospitalization services only for those individuals who meet Medicare requirements.

Without dollar amounts being specified, certain current law civil money penalties cannot be implemented.

Current law provides for criminal penalties or exclusion for those who violate the anti-kickback statute, both of which are very stiff remedies for a health care institution. A new CMP would provide an intermediate remedy. **Approved by OMB.**

A loophole exists in OIG's civil money penalty (CMP) authority which establishes a penalty for claims submitted by an excluded provider for items or services furnished directly by them. This existing CMP authority does not address (1) another party who provides a service ordered by an excluded provider, after that other party is put on notice of the exclusion, and (2) penalizing the excluded provider for ordering a service paid for by Medicare or Medicaid.

The OIG continues to have a problem with hospitals and other types of providers hiring individuals who are in excluded status. Hospitals are generally required to query the National Practitioner Data Bank (NPDB) regarding health care practitioners being hired or being granted clinical privileges. The NPDB includes all OIG exclusions. Also, hospitals are required to query the NPDB on all such practitioners every two years. Where an initial check of the exclusion list on a hiring is not done, or where the two-year check is not done, the CMP should apply. This CMP applies where the employer knew or should have known of the exclusion.

These investigative tools are needed in the complex investigations of fraud, kickbacks and other prohibited activities.

The 1995 decision of the Ninth Circuit (CA) in the Hanlester Network v. Shalala case radically interpreted the terms of the statute to put very high burdens of proof on the government. Although this case is binding only in that circuit, a return to the normal burden of proof in criminal cases should be made by legislation.
(Previously cleared by OMB.)

This proposal would close a loophole in the coverage of the anti-dumping statute.

- o **Increase Flexibility for Future Bad Debt Payments** - This proposal would give the Secretary the flexibility to revise the methodology for making payments to hospitals for bad debt from Medicare beneficiaries. (This proposal is budget neutral.)

Rationale: DHHS is under a moratorium, enacted in OBRA87, from changing any aspect of Medicare bad debt payment policy. Medicare currently reimburses hospitals for 100% of bad debt attributed to its beneficiaries. This proposal would lift the moratorium although no specific changes would be proposed at this point.

Provider Enrollment Process

- o **Improve the Provider Enrollment Process** - This proposal would clarify the provider enrollment process, and strengthen HCFA's ability to combat fraud and abuse by not allowing "bad actors" to become Medicare providers and/or suppliers.
 - First, the Secretary would have the authority to deny entry into Medicare those provider applicants that were convicted of a felony. HCFA would deny these applicants a billing number.
 - Second, the Secretary would be authorized to collect a fee for all Medicare and Medicaid applicants when they apply for enrollment or re-enrollment. If an application is denied, a six-month waiting period must be completed before the provider could reapply. The fee would cover administrative costs in processing the application and administering the HIPAA National Provider Identification program requirements to validate applications. If HCFA determines that an overpayment has occurred, the payment must be recouped before the provider would receive another billing number.
 - Third, this proposal would enhance the provider enrollment process by screening for potential fraudulent Medicare providers and suppliers. The Secretary would receive authority to require providers, physicians and other suppliers, managing

employees, and all owners of providers and suppliers to disclose both their Employer Identification Numbers (EINs) (where an EIN exists) and their Social Security Number (SSNs). The Social Security Administration would be required to verify the validity of the SSN's.

- Fourth, this proposal would close a loophole which allows an entity to inappropriately escape an exclusion in certain circumstances. Under current law, the Secretary may exclude an entity which is owned or controlled by an excluded individual. However, some entities are escaping this provision by the excluded individual transferring the ownership to an immediate family member, although the excluded individual remains in "silent" control. This new provision allows the Secretary the discretion when making the determination whether to exclude to disregard such a transfer of ownership.

Rationale: The proposal improves the provider enrollment process by enhancing HCFA's tools for identifying and reducing fraud and abuse. Denying convicted felons entry into Medicare safeguards the program. Requiring a Medicare applicant fee and instituting a six-month waiting period after denial of entry improves HCFA's ability to process applications. The disclosure of provider and supplier EINs/SSNs increases the ability to deny Medicare entry to fraudulent and unscrupulous applicants. It would also enhance HCFA's/HCFA contractor ability to: identify related entities; detect prospective providers, physicians and other suppliers who should not be allowed to become participants in the Medicare program; and identify situations where existing providers, physicians and other suppliers improperly employ/utilize excluded individuals/entities. Charging user fees for provider numbers provides administrative savings. This user fee also helps HCFA cover the costs of administering the National Provider Identification program, required by HIPAA.

Prudent Purchasing

- o **Bankruptcy Provisions** - These proposals would protect Medicare and Medicaid interests in bankruptcy situations. - A provider would still be liable to refund overpayments and pay penalties and fines even if he filed for bankruptcy. Quality of care penalties could be imposed and collected even if a provider was in bankruptcy. Medicare suspensions and exclusions (including for not re-paying scholarships) would still be in force even if a provider files for bankruptcy. If Medicare law and bankruptcy law conflict, Medicare law would prevail. Bankruptcy courts would not be able to re-adjudicate our coverage and/or payment decisions.

Rationale: This bankruptcy provision would provide us with improved standing under bankruptcy law. When providers, suppliers or third party payers go out of business, whether due to discovery of fraudulent behavior or not, Medicare

would be in a strengthened position to regain any wrongly paid monies. Additionally, this proposal would ensure that individuals and plans that owe financial obligations to Medicare, (or who have been excluded) would not be able to seek relief from the bankruptcy courts.

- o **Value of Capital When Ownership of an Institution Changes-** This proposal would deem the sales price of an asset to be its net book value. The proposal would also apply to all providers.

Rationale: There have been instances in which SNFs or hospitals currently game the system by creating specious "losses" in order to be eligible for additional Medicare payments. For example, a seller might claim that a significant portion of the purchase price of a hospital is attributable not to the value of the hospital building and other capital assets, but to the value of the certificate of need, the already assembled hospital staff, or some other intangible asset. By minimizing the value attributable to the capital assets, the seller is able to record a lower sales price, and a greater "loss" on the sale. The seller is then entitled to partial reimbursement for the loss from Medicare. This existing loophole is especially problematic in the case of hospitals paid under PPS for capital because the prospective capital payments to the new owner are unaffected by the low valuation of the hospital (prior to PPS, the new owner would be somewhat disadvantaged by the gaming because their cost-based capital payments would have been lower because of the low sales price). Further, this proposal would eliminate the need for any payment adjustments for gains or losses.

- o **Clarify the Definition of Skilled Services -** This proposal would exclude venipuncture from the eligibility criteria for intermittent skilled nursing services. Venipuncture currently qualifies as skilled nursing care and therefore meets the eligibility criterion for intermittent skilled nursing services under the home health benefit. If the other criterion are met (homebound, etc.), then a beneficiary who only requires venipuncture for the purpose of obtaining a blood sample as his/her qualifying skilled need, would be entitled to all of the other covered home health services including home health aide services. If venipuncture for the purpose of obtaining a blood sample is the only skilled service that is needed by the beneficiary, that individual should not be eligible for the home health benefit.

Rationale: Eliminating venipuncture as a qualifying skilled service for Medicare home health eligibility will limit payments for other home health services for beneficiaries who would otherwise be ineligible for services under the home health benefit.

- o **Hospice Benefit Modifications -** This proposal would revise hospice coverage and payment policies.

First, after the two initial 90-day periods this proposal would replace the current third and fourth hospice benefit periods with an unlimited number of thirty-day periods.

Second, as the President's FY98 budget bill proposed for home health, this proposal would link payment for hospice services to the geographic location of the site where the service was furnished.

Third, this proposal would also clarify that a hospice cannot receive payment from Medicare for dually eligible beneficiaries who reside in a nursing home. (In cases where a beneficiary receives hospice care in his or her own home and, subsequently, needs to enter a nursing home, Medicare would pay the hospice the routine home care rate for a period not to exceed 10 days for necessary services required for the transition into the nursing home; there would be a lifetime maximum of two 10-day transition periods under the revised benefit.)

Fourth, this proposal would also limit beneficiary liability under hospice care. Currently, the major cause for denial of hospice claims is the fact that the beneficiary was not terminally ill within the meaning of the law (i.e., did not have a prognosis of six months or less of life at the time the services were rendered). If a hospice claim is denied because the patient was not terminally ill, the patient's liability for payment would be waived and the hospice would be liable for the overpayment unless it could prove that it did not know or have reason to know the claim would be disallowed. The standard of proof would be high since both the law and HCFA instructions are explicit as to the requirement and there are well established protocols for documentation of medical prognosis.

Rationale: This proposal would allow HCFA to ensure that the hospice benefit is used for those beneficiaries with a terminal illness, but it would not terminate hospice care from those fortunate to survive longer than expected. This proposal would also ensure that payments reflect the prevailing costs in the areas where services are furnished, not the higher cost urban areas where agencies tend to locate their parent offices. Additionally, under current law, when dual eligibles who are nursing home residents elect the Medicare hospice benefit, Medicaid continues to pay to the nursing home at least 95% of the full nursing home rate (which includes both room and board and to some extent, medical and social services) and Medicare pays the hospice per diem (which covers the provision of all hospice benefits, including medical nursing, home health aide, and social services). We believe the revised nursing home requirements mandated by OBRA-87 already require nursing homes to provide palliative care for terminal illnesses. Under current law, a beneficiary receiving hospice care is unprotected from financial liability should the beneficiary turn out to be not terminally ill. A hospice may seek full payment from the beneficiary for denied claims for hospice care. The proposal would provide beneficiaries

with protection in cases where they receive hospice care services in good faith, even if they are not, in fact, terminally ill. A similar proposal was approved by OMB. (Although that proposal would have limited hospice to 360 days per beneficiary.)

Rural Health Clinics

- o **Rural Health Clinic (RHC) Benefit Reforms-** This proposal contains several provisions which would reform the RHC benefit under Medicare. The proposal would hold provider-based RHCs to the same payment limits as independent RHCs. The Secretary would develop a prospective payment system for RHCs no later than December 31, 2000. Under such a prospective payment system, beneficiary cost sharing would be based on 20 percent of the PPS amount. Beneficiary cost sharing (prior to the development of a PPS system) could not exceed 20 percent Medicare's payment limit.

This proposal would also limit application of the waiver of the staffing requirement so that it is available only to participating RHCs. Under current law, both participating RHCs and RHC applicants may receive one-year waivers of the requirement to employ at least 50 percent of the time a nurse practitioner, physician assistant, or certified nurse midwife if the facility has been unable despite reasonable efforts, to hire a nurse practitioner, physician assistant, or certified nurse midwife. This proposal would also require each RHC to implement a quality assessment and improvement program (which includes utilization review) rather than just a utilization review program as required under current law.

The proposal would also include several provisions to better target the placement of rural health clinics. Section 1861(aa)(2) of the Act currently requires RHCs to be located in an area designated by the Health Resources and Services Administration (HRSA) pursuant to certain sections in the Public Health Service (PHS) Act or an area designated by the governor and certified by the Secretary as an area with a shortage of personal health services. This proposal would revise the statute under section 1861(aa)(2) of the Act to require that any eligible area in section 1861(aa)(2) used for qualifying an RHC must have been designated or reviewed for redesignation within the 3-year time period prior to an applicant's request to participate in Medicare/Medicaid as an RHC. (Note: HRSA is proposing a 3-year review of all medically underserved areas pending regulations).

The proposal would also revise the statute under section 1861(aa)(2) of the Act to establish a time/distance standard for RHC qualification to help HCFA determine where Medicare and Medicaid beneficiaries have limited access to primary care services. This proposal would apply to participating RHCs as well as new RHC applicants. The time/distance standards would be measured by a travel time greater than 30 minutes from the RHC applicant to a qualified provider (participating RHC or FQHC). The following criteria would be used in determining distances corresponding to 30 minutes travel time --

(1) 20 miles under normal conditions with primary roads available and (2) 15 miles in areas with only secondary roads available. These are general distance standards applied by HRSA in determining underserved. Time and distance standards could be waived by the Secretary for any facility that demonstrates need for primary care services in the community. Specifically, a waiver would be granted if existing facilities in the area are at capacity or the current providers limit their services by age group or gender. The proposal would also require that a RHC be located in an area where there are insufficient numbers of practicing nurse practitioners, physician assistants, nurse midwives and other practitioners.

The proposal would also revise the statute to eliminate the provision which allows a provider to preserve its RHC status regardless of the fact that the area is no longer underserved or rural. HCFA would terminate all RHCs in an area in which HRSA determines is no longer a shortage area and removes the area from its list of designated shortage areas. Similarly, HCFA would terminate all RHCs in an area which the Bureau of the Census has redefined to be an urbanized area. In light of fact that some shortage area designations are sensitive to the presence or absence of one health care professional, the proposal would allow RHCs to retain their certification for three years following de-designation of a shortage area by HRSA.

Rationale: Since all RHCs provide the same scope of services, we believe as a matter of equity and fairness that there should be uniformity in payment for the same services whether provided in independent or provider-based RHC settings. A recent GAO report agrees, and recommends that the same payment limit and cost reporting requirements which apply to independent RHCs should also be applied to facility-based RHCs.

We implemented the current staffing waiver language to apply both to participating RHCs or RHC applicants. We believe now, with the benefit of industry advice, that physician offices attempting to convert to RHC status should be required to meet all RHC conditions of participation at the time of application including a mid-level practitioner on staff. The intent of the law is for mid-level services to be available in an RHC, and the waiver provision should not be an incentive to physicians to convert to RHC status so that the physician could receive possible RHC cost-reimbursement despite the lack of a mid-level practitioner on staff. By requiring quality assurance and improvement programs, an RHC would be better able to assess and improve quality of care provided to its patients.

HCFA must rely on HRSA to determine when an area is medically underserved. Unfortunately, HRSA's process for disqualifying such areas is lagging behind the rapid growth of RHCs. The OIG has recommended that HCFA ensure that designations are accurate and up-to-date and that

areas are de-designated as appropriate and in a timely manner. Also, HRSA's service area designations tend to overstate need for primary care services because they do not consider mid-level practitioners. Consequently, because the RHC statute mandates dependence on HRSA's designation process, HCFA is unable to deny approving additional RHCs within areas which already have a sufficient number of primary care providers.

Also, as a result of the program's broad eligibility criteria, we now have clusters of RHCs in certain service areas. This proposal establishes specific program qualification criteria, in addition to rural and underserved, to give HCFA the authority to directly challenge the "shortage" of an area when pending applications or existing RHCs are concentrated in small geographical areas. The OIG has recommended that HCFA establish new criteria, in addition to rural and underserved designations, that would document need and impact on access of new RHCs, including geographic limits to eliminate the concentration of RHCs.

In order to remove some of the barriers to access of care for rural underserved Medicare and Medicaid beneficiaries, Congress enacted several provisions, including the grand fathering provision, to promote the development of RHCs and to ensure that rural residents would have access to care despite possible changes in area designations. During the recent period of extensive RHC growth, we have observed that RHCs have used the grand fathering protection to continue operating even when the area is fully served or is no longer rural.

Mental Health

Clarify the Partial Hospitalization Benefit -- This proposal would establish coverage requirements and limitations to minimize program abuse. This proposal would also preclude providers from furnishing partial hospitalization services in a beneficiary's home or in an inpatient or residential setting. It would also provide the Secretary broad authority to establish through regulation a prospective payment system for partial hospitalization services that reflects appropriate payment levels for efficient providers of service and payment levels for similar services in other delivery systems. (The current cost reimbursement system would stay in place until the Secretary exercises this payment authority.)

Rationale: This proposal would discourage development of partial hospitalization programs targeted to patients in their homes or in settings where there is a residential population, such as nursing facilities and assisted living facilities. Finally, the partial hospitalization benefit was intended to be a less-costly

alternative to inpatient psychiatric care. The current reasonable cost reimbursement methodology has resulted in excessive payment and inappropriate payment for items and services that are excluded from the definition of partial hospitalization services.

Define CMHCs for Medicare Participation -- This proposal would provide authority for the Secretary to establish through regulation Medicare participation requirements for CMHCs (health and safety requirements, provider eligibility standards). Additionally, it would provide authority for CMHCs to be surveyed by state agencies to determine compliance with Federal requirements or investigate complaints upon request. This proposal will be accompanied by a user fee or specific appropriation for survey money. It would also prohibit Medicare-only CMHCs.

Rationale: Currently, a CMHC is defined as an entity that provides certain mental health services that are listed in the Public Health Service Act and meets applicable state licensing or certification requirements. Since 2/3 of the states do not license or certify CMHCs, this definition is insufficient to ensure that appropriate organizations become Medicare providers. Prohibiting Medicare-only CMHCs would discourage establishment of programs targeted to Medicare beneficiaries.

G:\MEDPARTALOR\COMBOS.313

Draft (3:30 p.m. 3/13/97)

Talking Points
Medicare Anti-Waste, Fraud, and Abuse Legislation

- Preserving and modernizing our Medicare program is a vital part of preparing our nation for the 21st Century. My balanced budget includes a series of Medicare reforms that will make this vital program more efficient, more effective, and better able to meet the needs of senior citizens and people living with disabilities.
- An important part of modernizing Medicare, is making sure that this program and the 37 million Americans it serves is safeguarded against waste, fraud, and abuse.
- Since my Administration began, we have made it clear that we have absolutely zero tolerance for individuals and corporations that attempt to defraud the Medicare system!
- I am proud of the fact that my Administration has achieved a record level of penalties and settlements in cases involving fraud. Beginning in 1993, my Administration has aggressively searched for the few bad players that give this business a bad name. As a result, we have recovered more than \$29 billion in just four years.
- Two years ago, Secretary Shalala and I launched Operation Restore Trust, a vigorous new effort to crack down on those who defraud our Medicare program. We started this effort in five states, including the state of Florida. Working in partnership with the Justice Department, the Office of the Inspector General, and the Health Care Financing Administration, Operation Restore Trust has already achieved some impressive results - saving nearly 10 dollars for every dollar we spent. Let me give you two examples of fraud that we have uncovered right here in Florida.
- In one case, our investigators found a medical equipment supplier who had previously been convicted of securities fraud. When we busted him, he had already billed Medicare for more than \$100 million. He's now back in jail, serving a five-year sentence.
- In another case, we found that one man had opened more than 120 companies by using 40 different fabricated names. After we caught him, he pleaded guilty to fraud and is in prison awaiting sentencing.
- We must do everything in our power to protect the sanctity of the Medicare program. Earlier this year, in my balanced budget plan, I included a series of proposals to crack down on waste, fraud, and abuse while we work to extend the solvency of the Medicare trust fund for a decade.

- Today, I am announcing that I will send Congress the "Medicare and Medicaid Anti-Fraud and Abuse Amendments of 1997." This is a package of nearly a dozen changes in Medicare and Medicaid rules that will allow us to do even more to keep the bad apples out of these two programs.
- First, my bill will empower the Secretary of Health and Human Services to exclude from Medicare and Medicaid anyone who has been convicted of a felony.
- Second, it will require anyone who wants to do business with Medicare to register with the government and give us their Social Security numbers. And if we find a problem, we will require these individuals to come back to us with a plan within six months that will address the problems we found. *providers*
- Third, we are tightening and toughening our sanction authorities so that we can make sure that those who cheat the Medicare and Medicaid programs will pay a price.
- And, fourth, we are closing a series of loopholes that have allowed people to abuse our bankruptcy laws, and programs designed to provide mental health and hospice care benefits.
- These are important steps. They will save the government and the people of this country a lot of money. But more importantly, they will provide each of us with a greater sense of security -- a peace of mind -- that our hard-earned tax dollars are paying for the care we need and not lining the pockets of frauds and cheats.

HC - Medicare Fraud

PRESIDENT WILLIAM J. CLINTON
REMARKS FOR MEDICARE FRAUD EVENT
THE WHITE HOUSE
MARCH 24, 1997

25

Acknowledgments: Sec. Shalala; Governor Chiles;
Bruce Vladeck, HCFA; Jamie Gorelick; June Gibbs
Brown (HHS Inspector General); representatives of
AARP.

As you know, I was recently reminded -- the hard
way -- that American doctors and American medicine are
the best in the world. That is certainly true of Florida's
doctors, nurses, and hospitals. I have worked hard to give
all American families access to quality health care. And
as Governor Chiles and Secretary Shalala have made
clear, a critical part of that mission must be to make sure
that the world's best medical system is free from fraud.

Over the past four years, we have made real progress in our effort to expand access to health care. Last year, we made it possible for working people to take their health insurance with them from job to job. My balanced budget plan will provide health care coverage for 5 million children who don't have it. It preserves and strengthens the Medicare system, ensuring the life of the Medicare trust fund for another decade. And today, we are taking the next steps to end the waste, fraud and abuse in health care that threatens our ability to provide high quality and affordable care for our parents.

Medicare fraud costs us billions of dollars every year. It amounts to a "fraud tax" that falls on all taxpayers, but most heavily on senior citizens. Because of fraud, they have to pay higher premiums and out-of-pocket costs they shouldn't have to pay.

Medicare and Medicaid are more than just programs. They are the way we honor our duty to our parents, the way we strengthen our families. We cannot tolerate fraud that robs taxpayers as it harms our parents.

The law enforcement partnership described by Governor Chiles and Secretary Shalala has made real strides in the fight against health care fraud.

Over the past four years, we have assigned more Justice Department prosecutors and more FBI agents to fight health care fraud than ever before. As a result, we have won a record number of convictions and settlements in fraud cases. All told, since 1992 the number of health care fraud convictions has increased by 241 percent.

Operation Restore Trust, which Secretary Shalala described, has the potential to save \$10 for every dollar spent.

All these efforts have helped save over \$20 billion in health care claims -- money that would have been wasted has gone instead to help to provide quality health care and peace of mind for our families.

Today I am pleased to announce that I will send to Congress legislation to continue and toughen our crackdown on Medicare and Medicaid fraud and abuse.

First, the best way to prevent fraud is to keep dishonest doctors and other scam artists out of the Medicare system in the first place.

Under my bill, a provider or supplier who has been convicted of fraud or another felony could be barred from joining the Medicare and Medicaid programs. For example, in Florida our investigators found a medical equipment supplier, previously convicted of securities fraud, was bilking Medicare. He was ordered to pay \$32 million in restitution, and he's back in jail, serving a 9-year sentence. But people like this should not be allowed to join Medicare in the first place. With this legislation, they won't be.

Second, our reforms would improve safeguards against fraud by requiring anyone who wants to do business with Medicare to register with the government and give us their Social Security number. This will help us track and stop fraudsters who try to repeat their crimes, setting up shop under phony names, with dummy corporations, or in new states.

Third, this legislation will toughen sanctions so that those who cheat, pay the price. The government will have a stronger hand in imposing new and larger civil, monetary fines.

And fourth, it will close loopholes in the law that let Medicare and Medicaid providers pocket overpayments from the government, simply by declaring bankruptcy. Under this bill, Medicare providers will no longer be able to avoid accountability by declaring bankruptcy.

These are important steps. They will save the government and the American people a great deal of money. But they will also buy something that money cannot -- a greater sense of security and peace of mind for our parents and our poorest citizens.

We can and we will preserve Medicare; and the steps we are taking today will protect and strengthen the Medicare system that means so much to our families well into the future.

Thank you.

WHITE HOUSE STAFFING MEMORANDUM

9:00 am

DATE: 3/24/97

ACTION/CONCURRENCE/COMMENT DUE BY: 3/25/97

SUBJECT: Remarks - Medicare's Fraud Announcement

	ACTION	FYI		ACTION	FYI
VICE PRESIDENT	<input checked="" type="checkbox"/>	<input type="checkbox"/>	McCURRY	<input type="checkbox"/>	<input checked="" type="checkbox"/>
BOWLES	<input checked="" type="checkbox"/>	<input type="checkbox"/>	McGINTY	<input type="checkbox"/>	<input type="checkbox"/>
McLARTY	<input type="checkbox"/>	<input type="checkbox"/>	NASH	<input type="checkbox"/>	<input type="checkbox"/>
PODESTA	<input checked="" type="checkbox"/>	<input type="checkbox"/>	RUFF	<input checked="" type="checkbox"/>	<input type="checkbox"/>
MATHEWS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	SMITH	<input type="checkbox"/>	<input type="checkbox"/>
RAINES	<input checked="" type="checkbox"/>	<input type="checkbox"/>	REED	<input checked="" type="checkbox"/>	<input type="checkbox"/>
BAER	<input checked="" type="checkbox"/>	<input type="checkbox"/>	SOSNIK	<input checked="" type="checkbox"/>	<input type="checkbox"/>
ECHAVESTE	<input type="checkbox"/>	<input type="checkbox"/>	LEWIS	<input checked="" type="checkbox"/>	<input type="checkbox"/>
EMANUEL	<input checked="" type="checkbox"/>	<input type="checkbox"/>	YELLEN	<input type="checkbox"/>	<input type="checkbox"/>
GIBBONS	<input type="checkbox"/>	<input type="checkbox"/>	STREETT	<input type="checkbox"/>	<input type="checkbox"/>
HALE	<input type="checkbox"/>	<input type="checkbox"/>	SPERLING	<input checked="" type="checkbox"/>	<input type="checkbox"/>
HERMAN	<input type="checkbox"/>	<input type="checkbox"/>	HAWLEY	<input type="checkbox"/>	<input type="checkbox"/>
HIGGINS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	WILLIAMS	<input type="checkbox"/>	<input type="checkbox"/>
HILLEY	<input checked="" type="checkbox"/>	<input type="checkbox"/>	RADD	<input type="checkbox"/>	<input type="checkbox"/>
KLAIN	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<u>Chris Jennings</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
BERGER	<input type="checkbox"/>	<input type="checkbox"/>	<u>Waldman</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
LINDSEY	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

REMARKS:

Comments to Jordan Tamaghi.

RESPONSE:

PRESIDENT WILLIAM J. CLINTON
REMARKS FOR MEDICARE FRAUD EVENT
THE WHITE HOUSE
MARCH 24, 1997

Acknowledgments: Sec. Shalala; Governor Chiles; Bruce Vladeck, HCFA; Jamie Gorelick; June Gibbs Brown (HHS Inspector General).

As you know, I was recently reminded -- the hard way -- that American doctors and American medicine are the best in the world. That is certainly true of Florida's doctors, nurses, and hospitals. I have worked hard to give all American families access to quality health care. And as Governor Chiles and Secretary Shalala have made clear, a critical part of that mission must be to make sure that the world's best medical system is free from fraud.

Over the past four years, we have made real progress in our effort to expand access to health care. Last year, we made it possible for working people to take their health insurance with them from job to job. My balanced budget plan would expand access to health care for 10 million children who don't have it.

And today, we are taking the next steps to end waste, fraud and abuse in health care as we work to ensure high quality and affordable care for our parents.

Medicare fraud costs us billions of dollars every year. It amounts to a "fraud tax" that falls on all taxpayers, but most heavily on senior citizens. Because of fraud, they have to pay higher premiums and out-of-pocket costs they shouldn't have to pay.

On this we have been very clear: We must have zero tolerance for any attempt to defraud the Medicare and Medicaid system. We cannot let criminals prey on the vital programs that protect our parents, our children and our families.

The law enforcement partnership described by Governor Chiles and Secretary Shalala has made real strides in the fight against health care fraud.

Over the past four years, we have assigned more Justice Department prosecutors and more FBI agents to fight health care fraud than ever before. As a result, we have won a record number of convictions and settlements in fraud cases. All told, since 1992 the number of health care fraud convictions has increased by 241 percent. Operation Restore Trust, which Secretary Shalala described, has saved \$10 for every dollar spent.

All these efforts have helped save over \$20 billion in health care claims -- money that went to help families instead of being wasted.

Today I am pleased to announce that I will send to Congress legislation to continue and

toughen our crackdown on Medicare and Medicaid fraud and abuse.

First, the best way to prevent fraud is to keep dishonest doctors and other scam artists out of the Medicare system in the first place. Under my bill, a provider or supplier who has been convicted of fraud or another felony would be barred from joining the Medicare and Medicaid programs.

Second, our reforms would improve safeguards against fraud by requiring anyone who wants to do business with Medicare to register with the government and give us their Social Security number. This will help us track and stop fraudsters who try to repeat their crimes, setting up shop under phony names, with dummy corporations, or in new states.

Third, this legislation will toughen sanctions so that those who cheat, pay the price. The government will have a stronger hand in imposing new and larger civil, monetary fines.

And fourth, it will close loopholes in the law that let providers pocket overpayments from the government, simply by declaring bankruptcy. Under this bill, Medicare providers will no longer be able to avoid accountability by declaring bankruptcy.

These are important steps. They will save the government and the American people a great deal of money. But they will also buy something that money cannot -- a greater sense of security and peace of mind for our parents and our poorest citizens.

We can preserve Medicare; we can make it better. The job has already begun and we won't quit until we've finished.

Thank you.

PRESIDENT CLINTON ANNOUNCES MEASURES TO FIGHT WASTE, FRAUD, AND ABUSE IN HEALTH CARE

Today, President Clinton announced plans to send Congress new legislation to fight waste, fraud, and abuse in health care. The "Medicare/Medicaid Anti-Waste, Fraud and Abuse Act of 1997" establishes tough new requirements for individuals and companies that wish to participate in Medicare or Medicaid. The new legislation follows on four years of focused effort by the Clinton Administration that has helped save more than \$20 billion in health care claims through policy changes, penalties, recoveries, claims denials, and settlements. The legislation will also build on the Justice Department's comprehensive efforts to fight health care fraud. Due to the Justice Department's increased resources, focused investigative strategies, and better coordination among law enforcement, the number of health care fraud convictions increased by 241 percent since FY 1992.

NEW LEGISLATION

Strengthening the Provider Enrollment Process. The bill makes a series of changes in provider enrollment rules, including:

- **Barring Felons.** The Secretary of Health and Human Services would be authorized to deny participation in Medicare and Medicaid for any person who has been convicted of a felony.
- **Requiring Provider Identification Numbers.** HHS would require health care providers applying for participation in Medicare or Medicaid to provide their Social Security numbers and their Employer Identification numbers for use as their provider identification number. The Health Care Financing Administration could then check an applicant's history for past fraudulent activity.
- **Requiring Remedial Action Plans.** Providers who are rejected for participation in Medicare or Medicaid would be required to submit a remedial plan and to wait six months before reapplying for participation.

New Sanctions. The Federal government's ability to levy sanctions against providers of Medicare services who commit fraud would be strengthened through the use of new civil monetary penalties, including:

- **Penalizing False Certification.** Physicians who falsely certify that an individual meets certain Medicare requirements would be subject to penalties.
- **Barring Kickbacks.** Providers that violate Medicare's prohibition against kickbacks -- such as referring a patient to a facility owned by the provider -- would be subject to penalties.
- **Prohibiting Hiring of Excluded Individuals.** Hospitals or other providers would be fined if they are found to have hired individuals who have been excluded from Medicare.
- **Specifying Civil Monetary Penalties.** The bill would specify dollar amounts for civil monetary penalties that may be imposed on certain providers.

Closing Loopholes. The President's proposal protects Medicare and Medicaid beneficiaries by closing loopholes that can allow fraud and abuse to occur.

- **Eliminating Fraudulent Use of Bankruptcy Protections.** The President's plan would close a loophole that allows Medicare and Medicaid providers and suppliers found to be engaging in fraudulent practices to avoid paying the administrative penalties and returning the money they owe by declaring bankruptcy.

- Eliminating Abusive Charges Under Home Health Care Benefits. This proposal would close a loophole in current law that automatically makes anyone who needs blood drawn at home eligible for a variety of more expensive home health services. Current law has allowed some providers to use an inexpensive service as a gateway to bill Medicare for other more lucrative services.
- Cracking Down on Abusive Uses of Medicare Reimbursement. Under the President's proposal, HHS would deem the sales price of a health care institution to be its net book value, closing a loophole that allows sellers to create a phony "loss" and take advantage of reimbursement from Medicare.
- Assuring Appropriate Billing for Mental Health Benefits. The President's proposal would halt providers from pretending to furnish partial hospitalization services in a beneficiary's home or in an inpatient or residential setting. The proposal would also provide authority for the Secretary of Health and Human Services to establish new tougher standards for Community Mental Health Centers (CMHCs), and would provide authority for CMHCs to be surveyed by state agencies to determine compliance with Federal requirements or investigate complaints upon request.
- Preventing Abuse of Hospice Benefits. This proposal would link payment for hospice services to the geographic location of the site where the service was furnished, as the President's FY 1998 budget bill proposes for home health care. This would allow payments to reflect the prevailing costs in the areas where services are furnished, not the higher cost urban areas where agencies tend to locate their parent offices.

PRESIDENT CLINTON'S FY 1998 BUDGET PROPOSALS

The policies proposed today are designed to work in tandem with other anti-fraud and abuse proposals in President Clinton's FY 1998 budget proposal. These proposals include:

- 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 provision eliminates higher reimbursements that accrue to HHAs with parent offices located in urban centers.
- Eliminating periodic interim payments to home health agencies. These payments were previously used to encourage Medicare participation and are now no longer necessary.
- Requiring all skilled nursing facilities (SNFs) to bill Medicare for all services (with some exceptions) their residents receive and prohibit payment to any entity other than the SNF for services or supplies furnished to Medicare-covered patients.

BUILDING ON PREVIOUS CLINTON ADMINISTRATION ACTIONS

Since taking office, President Clinton has made combating waste, fraud, and abuse in health care a major priority. President Clinton's first budget closed loopholes in Medicare and Medicaid that had allowed waste, fraud, and abuse to occur. And in 1993, at the President's urging, the Attorney General put fighting health care fraud at the top of the Justice Department's agenda. Since 1993, the Justice Department has dramatically increased health care fraud investigations, criminal prosecutions, and convictions. To build on these efforts, two years ago, the Clinton Administration launched Operation Restore Trust, a comprehensive anti-fraud initiative, in 5 key states. Since its inception, Operation Restore Trust has produced returns of \$10 in overpayments for every \$1 invested. In 1996, President Clinton signed the Kassebaum-Kennedy legislation into law, expanding Operation Restore Trust nationwide, and for the first time, creating a stable source of funding for fraud control.

Clinton to Offer New Steps to Eliminate Fraud in Health Care

By ROBERT PEAR

WASHINGTON, March 24 — President Clinton will soon propose new steps to crack down on health care fraud, following the discovery that many doctors still receive Medicare payments after their licenses have been revoked or they have been expelled from Medicare for professional misconduct.

Administration officials said Mr. Clinton would announce the legislative proposals in a ceremony at the White House on Tuesday.

In a new report, June Gibbs Brown, inspector general of the Department of Health and Human Services, found there was "no centralized source of information" on state actions revoking the licenses of doctors, dentists and other practitioners. As a result, Ms. Brown said, Medicare, the health care program for the elderly, and Medicaid, the program for the poor, often continue paying doctors who have lost their licenses.

The report also said the Administration had not carried out laws passed in 1996 and 1987 to help exclude unscrupulous doctors from Medicare and other Federal health care programs.

Under the Federal law passed last year, the Secretary of Health and Human Services was supposed to establish "a national health care fraud and abuse data collection program for the reporting of final adverse actions against health care providers, suppliers or practitioners." The law set a Jan. 1 deadline for the new program, but Federal health officials said that it had not yet been established.

Representative Christopher Shays, the Connecticut Republican who heads a subcommittee that monitors the Department of Health and Human Services, said today, "We will follow up on this, not to criticize the department, but to encourage prompt action."

The inspector general expelled 1,937 health care providers from Medicare for various offenses last year, double the number expelled in 1993 and four times the number barred in 1988.

Medicare officials have no estimate of how much these providers collected in Medicare payments. But the General Accounting Office, an investigative arm of Congress, said recently that fraud and abuse accounted for perhaps 3 percent to 10 percent of all Medicare outlays, or \$6 billion to \$20 billion of the \$197 billion Medicare paid last year.

In her report, Ms. Brown said: "Better controls are needed to prevent improper payments. Without improved controls, unsuspecting beneficiaries are vulnerable to the dangers of unfit and unscrupulous health care providers."

The huge sums spent under Medicare and Medicaid have proved irresistibly attractive to dishonest health care practitioners. In the last decade, Congress has repeatedly tightened the laws governing these programs, giving new powers to the Secretary of Health and Human Services to detect fraud and abuse. But scam artists have devised ever more clever schemes to outwit auditors and prosecutors.

For example, doctors move easily from state to state, Ms. Brown said. Thus, she said, "it is possible for providers who hold licenses in more than one state to have one license suspended or revoked by a state licensing board, and then relocate and continue to treat Medicare patients in another state."

In one instance, Federal investigators said that Medicare paid \$172,000 for services provided in Virginia by a doctor who had lost his license in Maryland and been forbidden to practice in New York and Ohio.

The doctor's patients are probably unaware of the disciplinary actions taken against him, the inspector general said.

Such health care providers "can endanger the lives of beneficiaries and should not be allowed to further abuse our health care system," Ms. Brown said.

One of the measures to be announced by Mr. Clinton would require doctors and other health care providers to list their Social Security numbers when they apply for permission to participate in Medicare or Medicaid. Doctors, home health agencies and medical supply companies often circumvent existing law by using different names to re-enter the programs after being expelled for fraud or other offenses.

The President will also ask Congress to close what he describes as loopholes, including one that has allowed some health care providers to avoid civil fines and other penalties by declaring bankruptcy.

White House documents show that Mr. Clinton will also propose these steps:

Hospitals, health maintenance organizations, home health agencies and medical equipment companies would be prohibited from hiring anyone who had been expelled from Medicare for misconduct and not been reinstated.

Any health care provider convicted of a felony could be expelled from Medicare and Medicaid, regardless of whether the crime was related to health care.

Providers expelled from Medicare or Medicaid could not re-enter the programs for at least six months, and they would first have to correct all the deficiencies for which they were cited.

In 1987, Congress required states to inform the Federal Government of "any negative action" taken by state authorities against doctors or other practitioners.

States were supposed to notify the Federal Government whenever they reprimanded or censured doctors or revoked their licenses.

But Ms. Brown found that the 1987 law "has not been implemented." As a result, she said, the "data bases that contain exclusion and adverse licensure actions are incomplete and inaccessible," making it difficult for Federal authorities to halt payments to doctors who have lost their licenses or been found incompetent.

Bruce C. Vladeck, administrator of the Federal Health Care Financing Administration for the last four years, agreed with many of the inspector general's recommendations.

"Licensing of health care professionals is a state responsibility, and most states have at best a very rudimentary system for maintaining and sharing licensure information with their sister states," Mr. Vladeck said. "They are even less able to make the information available for use by Federal agencies."

Claims for services to Medicare beneficiaries are reviewed and paid by private companies working under contract to the Government. Mr. Vladeck said he was instructing these companies to revise their computer programs to prevent payments to doctors who have lost their licenses.

Mr. Vladeck acknowledged that the Public Health Service "has not exercised its authority" under the 1987 law to collect and share information on doctors punished by state authorities for misconduct or fraud.

The New York Times

TUESDAY, MARCH 25, 1997

White House Defends Missile Accord

By STEVEN ERLANGER

WASHINGTON, March 24 — The White House moved quickly today to answer senior Republicans' criticism of an agreement governing missile defenses that President Clinton and President Boris N. Yeltsin of Russia signed in Helsinki, Finland.

The agreement sets out distinctions between shorter-range missile defenses, which are built to protect troops and ships, and defenses against longer-range strategic missiles, which are all but banned under the 1972 Antiballistic Missile treaty, known as the ABM treaty.

Because it is effectively an amendment to that treaty, the agreement must be ratified by Congress, either with a two-thirds vote by the Senate or a majority in both houses.

Bob Dole tried to make an issue of missile defenses during his unsuccessful campaign against Mr. Clinton in the 1996 presidential election. The most direct criticism from Republicans, though, has come from the House Speaker, Newt Gingrich of Georgia, and two senior Republican Congressmen — Bob Livingston of Louisiana and Christopher Cox of California.

In a statement issued Sunday, at a fueling stop on their way to an official visit to China, these Republicans said that the Helsinki agreement

"will halt the development of the most effective possible ballistic missile defense."

Robert G. Bell, director of Defense Policy and Arms Control at the National Security Council, said these Republicans would like to scrap the ABM treaty altogether, in order to build a space-based system of defense against strategic missiles.

In their statement, the Congressmen said: "We must protect American cities from accidental or erratic use of ICBMs by other countries not bound by this bilateral agreement." ICBMs refer to inter-continental ballistic missiles.

Administration officials say it would be impossible to design a system to protect against strategic missiles from countries other than Russia and still be in compliance with the ABM treaty.

The treaty, Mr. Bell said, is "the cornerstone of strategic stability." But he said last weekend's meeting in Finland showed that the treaty could be modified to allow for "highly effective" defenses against shorter-range missiles that now are a part of many military forces around the world.

The Helsinki agreement protects all six of the American missile defense projects under development, which Russia now acknowledges do

not violate the ABM treaty, Mr. Bell said.

The Congressmen also criticized an aspect of the agreement that prevents the development, testing and deployment of "space-based interceptors" as part of a theater missile defense.

Mr. Bell said that the Pentagon had no plans for such a system, which would be extremely expensive, and that the Helsinki agreement would not prevent the deployment of sensors in space to track missiles. The agreement does ban the testing of theater missile defenses against strategic missiles.

Mr. Bell said that Congress as a whole, in language approved over the past six years, instructed the executive branch to negotiate an agreement distinguishing theater from strategic missile defenses, and to incorporate specific speed and range limits for targets that were included in the Helsinki deal.

The agreement does not limit advanced research that could produce other kinds of missile defenses, like aerial lasers or rockets launched from airplanes, Mr. Bell said.

Without an ABM treaty, officials argue, it would not be safe to make the sharp cuts in strategic nuclear warheads — to 2,000 to 2,500 on each side — agreed upon in Helsinki.

New Drive to End Low-Income Housing Fraud

By MICHAEL JANOFSKY

WASHINGTON, March 24 — With his department asking Congress for a huge budget increase to maintain a major low-income housing program, Housing Secretary Andrew M. Cuomo said today that the agency was stepping up efforts to reduce fraud and abuse in the program that cost taxpayers millions of dollars a year.

Appearing at a news conference with Attorney General Janet Reno, Mr. Cuomo announced the "Get Tough" partnership with the Justice Department, which he said would reflect a new priority in his department — to search out landlords who are diverting money for their personal use and cheating tenants by ignoring problems that need repair.

"Our message to landlords is very simple: if you misuse Federal resources, we will find out, we will track you down and we will make you pay," Mr. Cuomo said. "What they're doing is illegal, it is wrong, it must end. Starting today, it will."

Mr. Cuomo said that problems with landlords who participate in the low-income program, known as Section 8, as well as in other programs serving the poor, have become widespread. The department, he said, will begin its crackdown in 50 cities against landlords to more than one million people in 445,000 Section 8 units.

Over all, the program provides

housing for about 4.3 million low-income people around the country, most of whom are elderly, disabled or families with children, at an annual cost to the Federal Government of about \$7 billion. In its budget request for fiscal 1998, the department is asking Congress for an additional \$5.6 billion — about 30 percent more than the current budget of \$19.2 billion — to cover expiring subsidy contracts with landlords and residents who participate in the program.

Mr. Cuomo said the housing department has already taken action against "dozens" of problem landlords over the last three years, including the former owners of Mott Haven VI in the Bronx, who housing officials contend did not maintain safe and sanitary conditions at the two-building complex. The department took possession of the complex two weeks ago and began foreclosure proceedings. A new management company took over last week.

Residents of the complex described apartments that were virtually falling apart out of negligence, with fallen ceilings, crumbling walls, leaky pipes, broken fixtures, shattered windows, an inoperable elevator and drug dealers operating openly on the corner.

But to help in what he expects to be hundreds of additional efforts against problem landlords over the next few years, Mr. Cuomo said the department was initiating steps to make it harder for landlords to con-

tinue fraudulent activities and avoid detection.

These measures include asking Congress for legislation that makes it harder for landlords to declare bankruptcy to delay or elude Federal action against them, a common response now. The department also intends to ask Congress for stiffer penalties for the fraudulent activities of landlords, turning some that are now prosecuted as civil cases into criminal offenses.

"These are tough measures," Mr. Cuomo said. "But in my opinion, this is a double crime: defrauding taxpayers of precious financial resources and, at the same time, subjecting residents to intolerable living conditions."

Further, Mr. Cuomo said, the department will ask Congress for an additional \$50 million, largely to hire outside contractors to investigate financial irregularities, inspect properties and help build court cases against offending landlords.

The money would also be used to train 100 housing department employees to help with enforcement of the new legislation, even as the department is trying to cut its work force to 7,500 in three years from 13,000 four years ago.

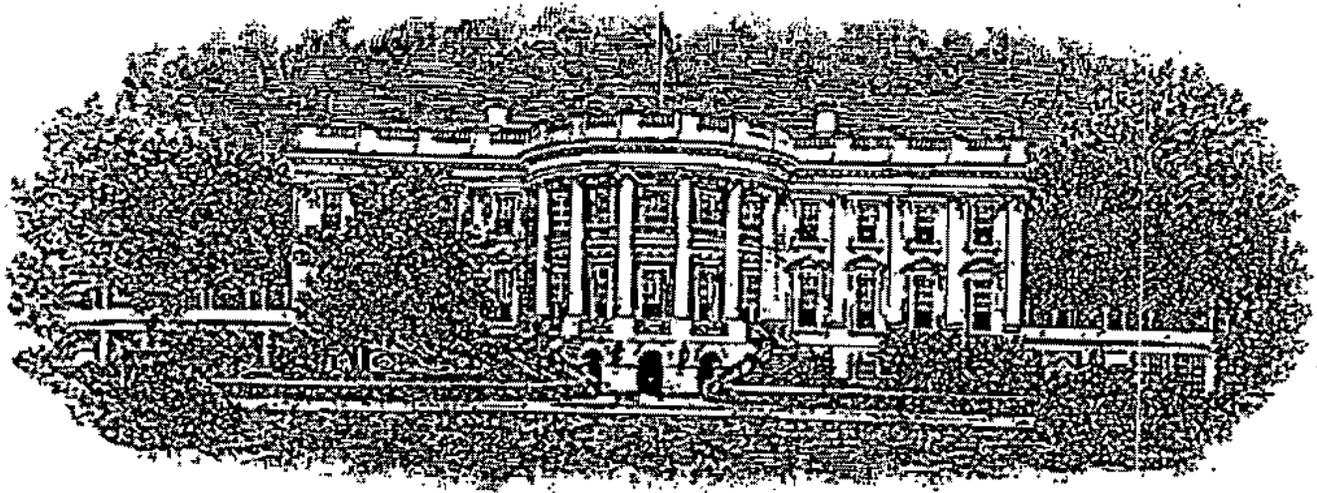
Ms. Reno pledged the full support of United States Attorneys across the country, saying they "stand ready to take on any case against unscrupulous landlords that HUD sends their way."

The New York Times

TUESDAY, MARCH 25, 1997

The White House

*Mr. Abraham
Frank*



DOMESTIC POLICY

FACSIMILE TRANSMISSION COVER SHEET

TO: Bruce Reed, Elena Kagan, & April Melody

FAX NUMBER: 6-2878 6-6423

TELEPHONE NUMBER: _____

FROM: Chris G.

TELEPHONE NUMBER: _____

PAGES (INCLUDING COVER): _____

COMMENTS: Attached is OAA for Pear article
We think background paragraph
should be upfront

Medicare/Medicaid Fraud and Abuse Prevention Act of 1997
Questions and Answers

Q: The New York Times reported today that the Department of Health and Human Services has not yet implemented two important anti-fraud and abuse laws. Why are you proposing these new measures when you haven't done what Congress has ordered?

A: First, the report referenced in today's article was done last November and concerned an HHS Inspector General audit conducted in only one state. There is no evidence of any systemic problem in this regard.

Second, the National Practitioner Data Bank was created by Congress in 1986 and began operating in September 1990. It includes licensing information only on doctors and dentists who have been the subject of punitive actions. That data bank is operating very well and, in fact, the Inspector General has praised the changes made by this Administration to improve its operation.

The most important thing to know is that the actions we are taking today -- things like Social Security numbers and stronger penalties -- will help us to find more cases of fraud and to prevent fraud in the first place. And we will have information on all providers, not just doctors and dentists.

~~[Background:~~ The new data bank called for in the Kennedy-Kassebaum Act will include all health care providers. Because the law wasn't signed until August 20, 1996, the January 1 deadline for action was unrealistic. The Department of Health and Human Services is proceeding on setting up that data bank as quickly as possible.]