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**The Department of Health and Human Services  
And  
The Department of Justice  
Health Care Fraud and Abuse Control Program  
Annual Report For FY 1997**

January 1998

## **FOREWORD**

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Fraud in the United States' health care system is a serious problem that has an impact on all health care payers, and indeed affects every person in this country. Further, dollars alone do not fully measure the impact of health care fraud on our nation. Fraudulent billing practices may also disguise inadequate or improper treatment for patients.

The Department of Health and Human Services and the Department of Justice, along with other federal, state and local agencies, are committed to aggressive efforts to enforce the law and prevent health care fraud. On-going efforts to attack fraud and abuse in federal health programs were consolidated and strengthened under the Health Insurance portability and Accountability Act of 1996 (HIPAA). HIPAA provided powerful new criminal and civil enforcement tools as well as expanded resources for the fight against health care fraud.

This first annual report of the Health Care Fraud and Abuse Control Program under HIPAA shows that we are making dramatic new headway. During 1997, the first full year of anti-fraud and abuse funding under HIPAA, we have recorded the most successful year ever in the nation's efforts to detect and punish fraud and abuse against federal health programs, in particular the Medicare and Medicaid programs. Not only are collections and enforcement actions at an all-time high, but much greater amounts are being returned to the Medicare Trust Fund. During 1997:

- \$1.087 billion was collected in criminal fines, civil judgments and settlements, and administrative sanctions.
- \$999 million was returned to the Health Care Financing Administration.
- More than 2,700 individuals and entities were excluded from federally sponsored health care programs — a 93 percent increase over 1996.
- Federal prosecutors opened 4,010 civil health care matters, an increase of 61 percent over 1996.

The success of this Program comes from the hard work done on a day-to-day basis by dedicated investigators, auditors, prosecutors, and support personnel across this Nation. As we highlight their contributions in this report, we must also aim at bringing about even greater participation by patients and honest health care providers in identifying and reporting fraudulent and abusive practices. Ultimately our success against fraud and abuse in health care rests on an attitude of "zero-tolerance" for fraud throughout our health care system.

Respectfully submitted,

Donna E. Shalala  
Secretary

Janet Reno  
Attorney General

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## GENERAL NOTE

All years are fiscal years unless  
otherwise noted in the text.

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## **EXECUTIVE SUMMARY**

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Many forms of health care fraud and abuse pose a threat to the health and safety of countless Americans, including many of the most vulnerable members of our society. To respond to this serious problem, Congress passed, and the President signed into law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). HIPAA provided powerful new criminal and civil enforcement tools and \$104 million in resources in 1997 dedicated to the fight against health care fraud. (Separately, the Federal Bureau of Investigation (FBI) received \$47 million which is discussed in the Appendix to this report.) In addition, HIPAA required the Attorney General and the Inspector General of the Department of Health and Human Services (HHS) to establish a coordinated national Health Care Fraud and Abuse Control Program ("Program"). The Program, established by the Attorney General and the HHS Inspector General in January 1997, provides a coordinated national framework for federal, state, and local law enforcement agencies, the private sector, and the public to fight health care fraud.

The first-year results of the Program demonstrate its effectiveness in meeting the goals established by Congress in HIPAA.

### **Civil and Criminal Enforcement Actions**

Civil and criminal health care fraud enforcement actions increased significantly in 1997. Federal prosecutors filed 282 criminal indictments in health care fraud cases in 1997 -- a 15 percent increase over the previous year. Similarly, the number of defendants convicted for health care fraud-related crimes rose from 307 in 1996 to 363 in 1997 -- an 18 percent increase. The number of civil health care matters also increased in 1997, with federal prosecutors opening 4,010 civil matters -- an increase of 61 percent over 1996.

### **Monetary Results**

In 1997, the Federal Government won or negotiated more than \$1.2 billion in judgments, settlements, and administrative impositions in health care fraud cases and proceedings. As a result of these activities, as well as prior year judgments, settlements, and administrative impositions, the Federal Government in 1997 collected \$1.087 billion in cases resulting from health care fraud and abuse. It should be noted that some of the judgments, settlements, and administrative impositions in 1997 will result in collections in future years, just as some of the collections in 1997 are attributable to actions from prior years.

A significant portion of the \$1.087 billion collected was the result of nationwide investigations into fraudulent billing practices of hospitals and independent laboratories. More than 93 percent of the funds collected and disbursed in 1997 -- \$999 million -- was returned to the Health Care Financing Administration (HCFA), where it will be used to provide medical care to the elderly and other needy Americans.

In addition, 326 Medicare coverage reviews were made in 19 states and overpayments in the amount of \$87.6 million were identified. HCFA is in the process of collecting these overpayments.

### **Exclusion from Federally Sponsored Programs**

HIPAA provided powerful new tools to prohibit companies or individuals convicted of certain health care offenses from participating in Medicare, Medicaid or other federally sponsored health care programs. In 1997, HHS excluded more than 2,700 individuals and entities from federally sponsored health care programs -- a 93 percent increase over 1996.

### **Preventing Health Care Fraud**

Preventing health care fraud and abuse is a central component of the Program. The Program's prevention efforts include the promulgation of formal advisory opinions to industry on proposed business practices, model compliance plans, special fraud alerts, and beneficiary and provider education and outreach.

## **INTRODUCTION**

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**ANNUAL REPORT OF  
THE ATTORNEY GENERAL AND THE SECRETARY  
DETAILING EXPENDITURES AND REVENUES  
UNDER THE HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM  
FOR FISCAL YEAR 1997**

**As Required by  
Section 1817(k)(5) of the Social Security Act**

The Social Security Act Section 1128C(a), as amended by the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191, HIPAA or the Act), established the Health Care Fraud and Abuse Control Program, a far-reaching program to combat fraud and abuse in health care, including both public and private health plans.

The Act requires the Attorney General and the Secretary to submit a joint annual report to the Congress which identifies:

- (A) the amounts appropriated to the Federal Hospital Insurance (HI) Trust Fund for the previous fiscal year under various categories and the source of such amounts; and
- (B) the amounts appropriated from the Trust Fund for such year for use by the Attorney General and the Secretary and the justification for the expenditure of such amounts.

This 1997 Annual Report thus discusses those funds which HHS and DOJ are required to deposit in the HI Trust Fund, and those funds which HIPAA appropriated from the HI Trust Fund.

The Act requires that an amount equaling recoveries from health care investigations -- including criminal fines, forfeitures, and civil and administrative penalties and judgments, but excluding restitution, compensation and relators' awards -- shall be deposited in the HI Trust Fund. All funds deposited in the Trust Fund as a result of the Act are available for the operations of the Trust Fund.

As stated above, the Act appropriated monies from the HI Trust Fund to a newly created expenditure account, called the Health Care Fraud and Abuse Control Account (the Account), in amounts that the Secretary and Attorney General jointly certify are necessary to finance anti-fraud activities. The maximum amounts available for expenditure are specified in the Act. Certain of these sums are to be available only for activities of the Office of Inspector General (OIG) of HHS, with respect to Medicare and Medicaid programs. To the extent that the remaining funds are not spent directly by HHS and the Department of Justice (DOJ) on establishment and operation of the Program, funds may be made available to other federal, state and local health care enforcement

organizations for purposes that further the Program. In the first year of operation of the Program, 1997, the Secretary and the Attorney General certified \$104 million for appropriation to the Account. A detailed breakdown of the allocation of these funds is set forth later in this report. These resources supplement the direct appropriations of HHS and DOJ that are devoted to health care fraud enforcement. (Separately, the FBI received \$47 million from HIPAA which is discussed in the Appendix.)

Under the joint direction of the Attorney General and the Secretary of Health and Human Services (HHS) acting through the Department's Inspector General, the Program's goals are:

- (1) to coordinate federal, state and local law enforcement efforts relating to health care fraud and abuse;
- (2) to conduct investigations, audits, and evaluations relating to the delivery of and payment for health care in the United States;
- (3) to facilitate enforcement of all applicable remedies for such fraud;
- (4) to provide guidance to the health care industry regarding fraudulent practices; and
- (5) to establish a national data bank to receive and report final adverse actions against health care providers.

### **HHS and DOJ Activities in 1997**

HIPAA, signed into law in August 1996, contained an aggressive timetable for implementation of the fraud and abuse control provisions of Title II. Funding under the Act began with 1997, with the Program and implementing guidelines to be in place no later than January 1, 1997. The overall Program required rapid initiation of a host of actions, including issuance of regulations (such as those governing a new process for issuing advisory opinions to the public on fraudulent health care transactions), initiation of negotiated rulemaking on anti-kickback penalties in the context of risk sharing arrangements, and initiation of a beneficiary incentive and outreach program. To make the most effective use of the tools and resources provided under HIPAA, HHS and DOJ, along with other federal, state and local agencies are joined in a coordinated national health care fraud enforcement and prevention program.

This collaborative effort resulted in numerous accomplishments, including the following achievements:

- In November 1996, HHS and DOJ signed a Memorandum of Understanding that set out procedures for the establishment of the Account, allocation of funds under the Program, expenditures of Account funds and accounting for such funds, tracking of recoveries under the Program, and overall evaluation of the Program.

- In January 1997, the Attorney General and the Secretary issued guidelines that provide a coordinated framework for enforcement and prevention efforts. The guidelines incorporated input from the law enforcement agencies charged with combating health care fraud.
- Civil and criminal health care fraud enforcement actions increased significantly in 1997. Federal prosecutors filed 282 criminal indictments in health care fraud cases in 1997 -- a 15 percent increase over the previous year. Similarly, the number of defendants convicted for health care fraud-related crimes rose from 307 in 1996 to 363 in 1997 -- an 18 percent increase. The number of civil health care matters also increased in 1997, with federal prosecutors opening 4,010 civil matters -- an increase of 61 percent over 1996.
- In 1997, the Federal Government won or negotiated more than \$1.2 billion in judgments, settlements, and administrative impositions in health care fraud cases and proceedings. As a result of these activities, as well as prior year judgments, settlements, and administrative impositions, the Federal Government in 1997 collected \$1.087 billion in cases resulting from health care fraud and abuse. It should be noted that some of the judgments, settlements, and administrative impositions in 1997 will result in collections in future years, just as some of the collections in 1997 are attributable to action from prior years. A portion of the judgments, settlements, and administrative impositions reflected here are the culmination of investigations and prosecutions begun before the effective date of the Program. Thus, resolution of these enforcement activities is not attributable solely to funding under the new Program. At the same time, many enforcement actions undertaken in 1997 will not result in collections until future years.
- 326 Medicare coverage reviews were made in 19 states and overpayments in the amount of \$87.6 million were identified. HCFA is in the process of collecting these overpayments.
- More than 2,700 individuals and entities were excluded from participation in Medicare, Medicaid and other Federal and state health care programs, due to their inappropriate activities -- a 93 percent increase over 1996.
- Many diverse initiatives were aimed at prevention of health care fraud and abuse, among them: (1) procedures for requesting and issuing formal advisory opinions were developed, and the first four opinions were issued; (2) HHS canvassed the health care industry and received suggestions on general issues in which industry guidance, in the form of safe harbors or special fraud alerts, was needed; (3) HHS and DOJ convened negotiated rulemaking on the issue of kickbacks in shared risk arrangements; (4) a model compliance plan for the clinical laboratory industry was issued; (5) HCFA, the Administration on Aging and the HHS/OIG joined with the private sector to survey beneficiary populations to assist in devising an effective outreach to educate the elderly to recognize and report fraud; (6) a total of 87 corporate integrity agreements were entered with parties in

connection with fraud settlements. DOJ and HHS continue to recommend legislative or regulatory changes to correct vulnerabilities to fraud, a number of such recommendations were adopted in the Balanced Budget Act of 1997 and are being implemented by HCFA.

- Of the funds made available for 1997, \$1.55 million was given to Federal, state and local agencies (other than HHS and DOJ) that are currently involved in health care fraud and abuse activities. In future months, these groups will be monitored for effectiveness in furthering the goals of the Program. These grants are described on page 30.

The remainder of this report provides a more detailed look at these and other accomplishments under the Program, and statistical data summarizing disbursement of collections and expenditures during the first year of its operation.

## MONETARY RESULTS

As required by the Act, HHS and DOJ must detail in this Annual Report the amounts deposited and appropriated to the HI Trust Fund, and the source of such deposits. In 1997, the combined anti-fraud actions of the federal and state governments and numerous private citizens produced remarkable outcomes with respect to collections as the result of successful investigations, negotiations and law suits. The Federal Government collected \$1.087 billion in connection with health care fraud cases and matters in 1997<sup>1</sup>. These funds were deposited with HCFA, transferred to other federal agencies administering health care programs, or paid to private persons. The following chart provides a breakdown of the transfers/deposits:

<b>Total Transfer/Deposits by Recipient 1997</b>	
<b>Health Care Financing Administration</b>	
HIPAA Deposits	
Gifts and Bequests	\$6,750
Amount Equal to Criminal Fines*	46,162,414
Civil Monetary Penalties	732,577
Amount Equal to Asset Forfeiture **	0
Amount Equal to Penalties and Multiple Damages	88,828,469
OIG Audit Disallowances - Recovered	302,288,607
Restitution/Compensatory Damages	560,576,678
	<b>998,595,495</b>
<b>Restitution/Compensatory Damages to Other Federal Agencies</b>	
Department of Veterans Affairs	22,131,850
National Institutes of Health	13,513,956
Office of Personnel Management	6,465,074
Department of Defense	6,334,917
Railroad Retirement Board	4,810,169
Other	2,276,621
	<b>55,532,587</b>
<b>Relators' Payments ***</b>	<b>33,169,932</b>
<b>TOTAL ****</b>	<b>\$1,087,298,014</b>

\*Reports to the Department of the Treasury were overstated by \$5,000,000 in 1997. A correction will be reflected in the 1998 HCFA Annual Report.

\*\*This includes only forfeitures under 18 United States Code (U.S.C.) 1347, a new federal health care fraud offense that became effective on August 21, 1996. Not included are forfeitures obtained in numerous health care fraud cases prosecuted under federal mail and wire fraud and other offenses.

\*\*\*These are funds awarded to private persons who file suits on behalf of the Federal Government under the qui tam provisions of the False Claims Act, 31 U.S.C. sec 3730(b).

\*\*\*\*Funds are also collected on behalf of state Medicaid programs and private insurance companies; these funds are not represented here.

<sup>1</sup>In 1997, DOJ collected an additional \$136,800,000 in health care fraud cases and matters that was not disbursed to the affected agencies and/or the Account in 1997 due to: (i) on-going litigation regarding relator shares in qui tam cases that will affect the amount retained by the Federal Government; (ii) receipt of funds late in the year that were then processed in 1998; and (iii) delays in recoding collections originally directed into miscellaneous Treasury receipts. Of this total, \$79,767,000 is still in suspense pending outcome of litigation; approximately \$40,893,000 has been disbursed in 1998 to the appropriate agencies and the Account; and, \$16,140,000 is expected to be so disbursed later in 1998.

The above transfers include certain collections, or amounts equal to certain collections, required by HIPAA to be deposited directly into the HI Trust Fund. These amounts include:

- (1) Gifts and bequests made unconditionally to the Trust Fund, for the benefit of the Account or any activity financed through the Account.
- (2) Criminal fines recovered in cases involving a federal health care offense, including collections under 1347 of title 18, U.S.C. (relating to health care fraud);
- (3) Civil monetary penalties in cases involving a federal health care offense;
- (4) Amounts resulting from the forfeiture of property by reason of a federal health care offense, including collections under section 982(a)(6) of title 18, U.S.C.;
- (5) Penalties and damages obtained and otherwise creditable to miscellaneous receipts of the general fund of the Treasury obtained under sections 3729 through 3733 Title 31, United States Code (known as the False Claims Act), in cases involving claims related to the provision of health care items and services (other than funds awarded to a relator, for restitution or otherwise authorized by law).

HIPAA requires an independent review of these deposits by the General Accounting Office (GAO). The GAO report is to be submitted to Congress by June 1, 1998.

## EXPENDITURES

In the first year of operation, the Secretary and the Attorney General certified \$104 million as necessary for the Program. The following chart gives the allocation by recipient:

<b>1997 ALLOCATION OF HCFAC APPROPRIATION</b> (Dollars in thousands)	
<b>Organization</b>	<b>Allocation</b>
Department of Health and Human Services	
Office of Inspector General	\$70,000
Health Care Financing Administration	5,346
Health Resources and Services Administration	2,000
Office of the General Counsel	1,800
Administration on Aging	<u>1,100</u>
<b>Total</b>	<b>\$80,246</b>
Department of Justice	
United States Attorneys	\$8,548
Civil Division	9,656
Federal Bureau of Investigation	3,625
Criminal Division	329
Justice Management Division	<u>42</u>
<b>Total</b>	<b>\$22,200</b>
Other Agencies	\$1,554
<b>Total</b>	<b>\$104,000</b>

These resources supplement the direct appropriations of HHS and DOJ that are devoted to health care fraud enforcement.

### Overview of Accomplishments

The Act centralizes coordination of all public and private health care fraud enforcement activities in a single program, led by HHS and DOJ, working in conjunction with: State Medicaid Fraud Control Units (MFCUs); Department of Defense (DOD), Defense Criminal Investigative Service (DCIS)(Civilian Health and Medical Program of the Uniformed Services - CHAMPUS, also called TRICARE); the United States Postal Service; the Internal Revenue Service; the Drug Enforcement Administration; the Office of Personnel Management (OPM), Office of Inspector General (Federal Employees Health Benefits Plan); Department of Veteran Affairs (VA), Office of Inspector General; the Food and Drug Administration; and the Department of Labor (DOL).

The Congress and the President recognized that close coordination among federal, state and local law enforcement agencies, as well as private insurers and health plans, is crucial to successfully detect, prosecute and prevent fraud in the vast health care industry.

Recent experience confirms the benefits of enhanced coordination. A two-year demonstration project, Operation Restore Trust (ORT), illustrated that extensive collaboration among law enforcement agencies would result in greater effectiveness and efficiency in preventing and detecting fraud and abuse in certain targeted services reimbursed by Medicare and Medicaid. Such coordination among government, industry, and the beneficiary population thus forms the essential foundation of the HCFAC Program.

HIPAA's landmark reforms bring critically needed resources and stronger enforcement tools to the battle against health care fraud and abuse. As envisioned by HIPAA, we have continued the successful partnerships forged earlier, expanding their membership and scope as necessary to address fraud and abuse throughout the health care industry. Nationally, the Executive Level Health Care Fraud Policy Group (composed of HHS/OIG, HCFA, HHS Office of General Counsel (OGC), FBI, and DOJ civil and criminal prosecutors), the National Health Care Fraud Working Group (composed of HHS, DOJ, DOD, DOL, VA, Department of the Treasury, OPM, United States Railroad Retirement Board, United States Postal Service, and the National Association of Attorneys General) and other bodies share information on both specific cases and overall trends. This national coordination is increasingly vital to curbing national schemes that cut across state lines and enforcement jurisdictions.

These national groups also sponsor training to enforcement personnel on detecting and prosecuting complex health care schemes. For example, the HHS/OIG and the FBI are together sponsoring four interagency training sessions regarding health care fraud and abuse. Building on the partnerships forged by the ORT demonstration project, the training is designed to further enhance agencies' understanding of the complexities of the federal health care programs. The focus areas of the training are: managed care (held in September 1997); durable medical equipment (held in December 1997); ambulance payments (to be held in 1998); and home health care (to be held in 1998). HHS/OIG also held an advanced training seminar for agents who have been with the HHS/OIG for two years or less. Held in September 1997, the advanced seminar focused on emerging issues. The next seminar is planned for April 1998. In addition, HCFA has provided training sessions on basic Medicare and Medicaid program issues. Developed by HCFA in collaboration with the HHS/OIG and FBI, this training enabled new agents and investigators to understand Medicare and Medicaid program policies and operation, and was conducted on a regional basis during 1997 and the first quarter of 1998. This training will also be provided to DOJ attorneys in 1998.

At the local level, more and more health care fraud working groups and task forces are getting underway. These working groups encourage communication and coordination among law enforcement officials in sharing information on specific cases, and selecting appropriate remedies. Local working groups have been encouraged to establish a liaison with licensing and

regulatory bodies, state officials, and private insurers. Task forces have also reached out to consumer and provider groups, so as to work together to identify fraudulent health care schemes, and to encourage referral of such information to the appropriate officials.

During this year, the Federal Government won or negotiated more than \$1.2 billion in judgments, settlements, and administrative impositions in health care fraud cases and proceedings. As a result of these activities, as well as prior year judgments, settlements, and administrative impositions, the Federal Government in 1997 collected \$1.087 billion in cases resulting from health care fraud and abuse, of which \$999 million was transferred to HCFA. These unprecedented figures are attributable, in large part, to the ongoing and expanded collaboration among health care oversight and enforcement officials at all levels of government and the private sector. It should be noted that some of the judgments, settlements, and administrative impositions in 1997 will result in collections in future years, just as some of the collections in 1997 are attributable to actions from prior years.

Working together, we have brought to successful conclusion the investigation and prosecution of some of the most far reaching and costly health care fraud schemes. Two significant successes include:

- Independent Clinical Laboratories: During 1997, the Federal Government achieved significant successes in its three-year task force effort targeting unbundling schemes whereby the nation's three largest independent clinical laboratories routinely billed Medicare for medically unnecessary tests, and for tests that the physician never ordered. The three laboratories agreed to pay a total of \$642 million to settle potential civil and or criminal liability to the federal and state governments. The Federal Government also required each corporation to enter a corporate integrity agreement to help safeguard against future fraud in laboratory billing practices.
- Diagnosis Related Groups (DRG) 72 Hour Window Project: A series of audits conducted by HHS/OIG disclosed that many hospitals were improperly billing Medicare for outpatient services rendered within 72 hours prior to and during a hospital admission, in addition to billing for the set fee DRG Medicare pays for each admission (which is supposed to include the outpatient services rendered within 72 hours prior to the admission). In response, HHS/OIG and DOJ launched a national initiative to recover these duplicate payments, and to compel hospitals to institute corrective measures to prevent such improper claims in the future. As of October 1, 1997, more than \$46 million has been returned to the Federal Government.

A more detailed description of the accomplishments of the major federal participants in the coordinated effort established under HIPAA follows. While information in this report is presented in the context of a single agency, most of these accomplishments reflect the combined efforts of HHS, DOJ and other partners in the anti-fraud efforts. After just one year of operation under the program, the successes of the Departments of Justice and HHS and our partners in the

coordinated anti-fraud effort already amply confirm that the increased funds to battle health care fraud and abuse were wisely invested.

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# FUNDING FOR DEPARTMENT OF HEALTH AND HUMAN SERVICES

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## Office of Inspector General

HIPAA mandates that the HHS/OIG receive a certain sum of money, within a stipulated range, for Medicare and Medicaid activities. During the first year of the Program, the Secretary and the Attorney General jointly allotted to these efforts the maximum statutory amount authorized: \$70 million. This represents an estimated \$27 million increase in available funds for the HHS/OIG to combat fraud in HHS-funded health care programs.

HHS/OIG was involved in more than 1,400 successful prosecutions and or settlements in 1997. More than 2,700 individuals and entities were excluded from doing business with Medicare, Medicaid and other federal and state health care programs as a result largely of criminal convictions (1101), licensure revocations (588), or other professional misconduct (1030) -- a 93 percent increase from the 1,400 exclusions in 1996. In addition to its role in bringing about the judgments and settlements described in the Executive Summary, HHS/OIG recommended and the Department disallowed \$84.5 million in improperly paid health care funds in 1997. HHS/OIG efforts also resulted in health care funds not expended (i.e. funds put to better use as a result of implemented HHS/OIG recommendations and other initiatives) of approximately \$6.1 billion for 1997.

These early successes are attributable, in part, to the additional staff and resources made available under HIPAA. During 1997, HHS/OIG staff levels increased from a little over 900 to 1,143 by the end of the year. In addition, HHS/OIG opened six new investigative offices and three new audit offices. Six more investigative offices will be opened during 1998. The staff of the HHS/OIG Office of Evaluation and Inspections has also increased, thereby strengthening the office's ability to conduct short term national evaluations that provide policymakers and managers with analysis and recommendations for improving the effectiveness and efficiency of HHS programs. The outcomes of these inspections can lead to increased cost savings, improved quality of care or services, improved program efficiency and the identification of program vulnerabilities. Overall, new staff has enabled the HHS/OIG to intensify and expand its activities in the health care field and to coordinate a more effective effort to curb Medicare and Medicaid fraud and abuse.

The additional resources and authorities granted by HIPAA have supported numerous important HHS/OIG projects. For example, HHS/OIG investigators and auditors have been instrumental participants in the marked success of many coordinated national initiatives, some of which are referenced above. In addition, HHS/OIG investigations and audits have supported numerous other significant criminal convictions and civil settlements in a number of different arenas in the

health care industry:

- **Home Health Agency Fraud:** First American Home Health Care of Georgia, formerly ABC Home Health Services, entered an agreement in settlement of charges that they filed false cost reports to Medicare; cost reports that included ghost employees, personal expenses, and political contributions, under which the owners agreed to pay the Federal Government \$255 million. This represents the culmination of an investigation that was ongoing for seven years.
- **Durable Medical Equipment - Incontinence Care Kits:** As part of the HHS/OIG's continued pursuit of fraud in the durable medical equipment industry, the HHS/OIG investigated one of the largest billers of Medicare for incontinence care products. The owner of this supply company was sentenced to 10 years imprisonment for billing Medicare for female incontinence care kits provided to nursing home patients, when he actually provided only adult diapers.
- **Administration of the Medicare Program:** After a two-year investigation, a former Medicare carrier, Blue Shield of California, agreed to pay \$12 million in settlement of its civil liability for having falsified its claims processing data and capabilities. The company also pled guilty to conspiracy, and obstruction of a federal audit, and was fined an additional \$1.5 million.

## **Audits**

Audit efforts are increasingly central to the detection of fraud against and vulnerabilities in health care programs. Foremost among these efforts is the audit of HCFA's financial statements. Initially mandated by the Chief Financial Officers Act, and expanded by the Government Management Reform Act of 1994, these annual financial statement audits provide an objective evaluation of the reliability of those statements and, importantly, include an evaluation of financial management processes, systems and internal controls. As part of this review, and for the first time in the history of the Medicare program, a comprehensive, statistically valid sample of fee-for-service claims was taken to determine the correctness of Medicare payments. The audit, jointly funded by HHS/OIG and HCFA, revealed estimated improper Medicare payments of approximately \$23 billion, or about 14 percent of total Medicare fee-for-service benefit payments made during the year. Most of the improper payments were attributable to insufficient or no documentation, lack of medical necessity, incorrect coding, and unallowable services. It cannot be established what portion of these improper payments are attributable to fraud. HCFA is already moving to correct these systemic weaknesses.

The HHS/OIG has also been redirecting some audit efforts away from just the traditional financial and performance audits that characterized HHS/OIG's activities in the past. Instead, many audit staff are being trained at the Federal Law Enforcement Training Center, and are then available to provide critical financial analysis and support to the Office of Investigations and DOJ on large, complex false claims cases. Audit assistance was central to the success of many of the joint

initiatives this year, among them, Independent Clinical Laboratories, and the DRG 72 Hour Payment Window Project.

### **Medicaid**

Another key HHS/OIG initiative has been to work more closely with state auditors in overseeing the Medicaid program. The HHS/OIG Office of Audit Services devised a Federal-State Partnership Plan that ensures more effective use of scarce audit resources by both the federal and state audit sectors. Partnerships have already been established with 19 state Auditors, 11 state Medicaid agencies and 2 state internal audit groups. Extensive sharing of audit ideas, approaches and objectives has taken place between federal and state auditors. Completed reports have involved a financial impact of \$140 million affecting both federal and state government funds.

### **Home Health**

The HHS/OIG also continued its focus on fraud and abuse in the home health industry. The Office of Audit Services conducted an audit of home health claims in 4 states, and found that 40 percent failed to meet Medicare reimbursement requirements. Most often, these services were found to be unreasonable or unnecessary, were provided to beneficiaries who were not homebound, or were not supported by valid physician orders or adequate documentation. At the same time, the Office of Evaluation and Inspections completed a study that revealed that Medicare's certification process did not adequately safeguard against participation by unscrupulous or abusive providers. In response to these reports, a temporary moratorium on new certification of new home health agencies was instituted, during which time program safeguards could be improved.

### **Prevention**

HIPAA has also allowed the HHS/OIG to redouble its efforts in preventing health care fraud and abuse. Through its new Industry Guidance Branch, the HHS/OIG, in consultation with the Attorney General, issued regulations stipulating a process for issuing written advisory opinions to the public on various legal issues arising under certain statutes enforced by HHS/OIG, including the Anti-Kickback Statute and the Civil Monetary Penalties Law. In accordance with those rules, a number of advisory opinion requests have been received and reviewed. The HHS/OIG also solicited and published proposals for modifications and additions to the so-called Safe Harbors, regulatory provisions which establish conditions for business structures or practices deemed nonabusive, and therefore, which will not be investigated or prosecuted under the Anti-Kickback Statute.

Working with DOJ, the HHS/OIG initiated a negotiated rulemaking specifically addressing anti-kickback penalties in the context of risk sharing arrangements. In another effort to avert future fraud, the HHS/OIG and DOJ have committed to including corporate integrity provisions in major settlements. The HHS/OIG is currently staffing up to thoroughly monitor the compliance reports

submitted by settling parties.

HHS/OIG continues to work with HCFA, the Administration on Aging (AoA) and various advocacy groups to develop an outreach campaign to educate beneficiaries and others who work directly with the elderly to recognize Medicare/Medicaid fraud, waste, and abuse when they encounter it, and know how and where to refer it. In this regard, the Office of Evaluation and Inspections operates an HHS/OIG Hotline, which serves as a point of contact for complaints of waste and fraud in the Medicare program (and other HHS programs). The HHS/OIG Hotline received approximately 58,000 telephone calls during the year, which resulted in more than 7,000 complaints. An estimated \$3 million in recoveries are associated with complaints resolved by HCFA and its contractors.

Another key aspect of prevention efforts is the HHS/OIG's responsibility for excluding offending providers from future participation in federal health programs. "Project WEED" is designed to improve the process whereby the Office of Investigations identifies abusive providers and, when appropriate, excludes them from Medicare and state health programs (including Medicaid). During the first year of the Program, the number of such exclusions nearly doubled, from 1,408 in 1996, to 2,719 in 1997. The majority of these exclusions were based on convictions for program-related crimes.

The HHS/OIG is also responsible for making recommendations to correct systemic vulnerabilities detected during reviews. A number of longstanding legislative recommendations were adopted in the Balanced Budget Act of 1997. These include recommendations related to HHS/OIG work in areas such as depreciation losses on hospital sales, and program controls for home health agencies and skilled nursing facilities, extensions to Medicare Secondary Payor provisions, prescription drugs, ambulance payments and indirect medical education costs.

### **Health Care Financing Administration**

The Health Care Financing Administration received \$5.3 million from the Account in 1997 for activities related to controlling fraud and abuse in the Medicare program. HCFAC Program funds were used for the following activities in FY 1997:

#### **Survey and Certification Medicare Coverage Reviews - \$1.8 million**

In 1997, HCFA received \$1.8 million from the HCFAC Program for Medicare coverage reviews. HCFA carries out Medicare coverage reviews by contracting with state agencies to conduct specialized surveys that are an expansion of traditional quality of care surveys. Medicare coverage review funding improved the exchange of information among HCFA, state agencies, Fiscal Intermediaries (FIs), and Regional Home Health Intermediaries (RHHIs). Medicare coverage reviews assist the FI and/or RHHI in identifying inaccurate billing, potential coverage problems, and potential waste, fraud, and abuse. Accordingly, Medicare coverage reviews provide FIs and/or RHHIs with the information they need to assess overpayments and implement collection

procedures.

The program supported the use of protocols whereby state survey and certification agencies provided information to Medicare contractors on the eligibility status of beneficiaries receiving services from laboratories, home health agencies, and skilled nursing facilities whose utilization and costs were extremely high. During 1997 326 surveys were made in 19 states and overpayments in the amount of \$87.6 million were identified. HCFA is in the process of collecting these overpayments.

#### **HCFA Customer Information System (HCIS) - \$1.9 million**

HCIS is the automation architecture being used to support the development and distribution of Medicare specific information to the Agency's legitimate customer base. HCIS is designed specifically to counter fraud and abuse in the Medicare program and will enable HHS/OIG and DOJ personnel to target aberrant providers, reduce investigative time, and improve actual recoveries to the Medicare Trust Funds.

HCIS accomplishes this in two ways -- (1) through the availability of summarized data that can be used to focus on specific areas of interest and (2) via access to beneficiary claim level data. These functions complement one another. For example, an auditor looking for patterns of Medicare fraud can use summarized data to focus an investigation to a specific area of interest. Since the investigation is focused at this point, the number of beneficiary claim detail records needed can be kept to a minimum. The smaller request set can later be used to process a request for complete detail data in the event the preliminary investigation warrants more comprehensive analysis. The system currently houses summarized data for home health agency, skilled nursing facility, hospice, inpatient, outpatient, and physician services.

#### **Los Alamos National Laboratory (LANL) - \$1.6 million**

In 1997, HCFA extended a contract with LANL to develop methodologies to identify fraud and abuse in the Medicare program. Scientists from LANL have examined the Medicare program and have developed algorithms and techniques to identify "suspicious" providers and to identify patterns of abuse. LANL is currently applying detection algorithms to historical claims data to develop a simulation that ranks the "suspiciousness" of a claim prior to payment. LANL will continue enhancement and examination of their fraud detection algorithms, and will test these techniques with additional provider types and in different demographic areas of the nation.

### **Health Resources and Services Administration**

The Act mandates that the HHS/OIG and DOJ establish a national health care fraud and abuse data collection program for the reporting and disclosure of certain final adverse actions (excluding settlements in which no findings of liability have been made) taken against health care providers, suppliers, and practitioners. The Health Resources and Services Administration (HRSA) has been

authorized to design, implement and operate this program, currently named the Healthcare Integrity and Protection Data Bank (HIPDB). In 1997, HRSA was allocated \$2 million for development under the Program; operating costs will be funded by user fees.

The HIPDB is being developed in stages as an all electronic system that will collect, store and disseminate reports on practitioners, providers and suppliers that have been found guilty of health related adverse actions through an adjudicated process. The reports will be made available to certain federal and state governmental authorities, including law enforcement agencies, and health plans. These same entities are mandated reporters to HIPDB.

HRSA used its National Practitioner Data Bank (NPDB) as a baseline and model in the planning and design of the HIPDB. More than 6,000 contacts and discussions with officials and representatives of other federal agencies, the major health plans and professional societies and licensing boards, and various state organizations in both the health and law enforcement communities were made for developing the initial requirements for the HIPDB. During this information gathering and requirements development phase, the concept of using the NPDB as a baseline and model was validated.

A milestone schedule has been developed for opening the HIPDB with an initial operating capability on March 10, 1998. Progress to date includes:

- implementing regulations and Notice of Proposed Rule Making (NPRM) developed and forwarded for release;
- design specifications developed and approved;
- specific design reviews conducted of key hardware and software;
- physical facility modified to accommodate the new equipment;
- equipment ordered, received and installed in the new facility;
- existing baseline NPDB software copied to the test machine; and
- software development begun.

In addition, data acquisition activities have begun that will result in data to populate the HIPDB. These activities include formal discussions with other federal agencies including:

- DOJ to acquire all federal judgments and convictions;
- HCFA to acquire Medicare and Medicaid adverse and exclusion actions; and
- Departments of Defense and Veterans Affairs to acquire disciplinary and adverse actions.

HRSA has also entered into preliminary discussions with various health care related and health professional organizations including those representing Nursing and Chiropractic Licensing Boards, to obtain information collected by them.

## Office of the General Counsel

The HHS Office of the General Counsel (OGC) worked in partnership with the DOJ and other HHS components (HCFA and the HHS/OIG) to combat health care fraud and abuse. OGC was allocated \$1.8 million in HCFAC funding for 1997. These funds were instrumental in recovering misspent monies of the Medicare Trust Funds, increasing overpayment recovery litigation, and implementing legislative and regulatory changes. This has resulted in a 65 percent increase in the number of new Program Integrity Litigation items for OGC.

The increases in OGC's funding and workload were accompanied by numerous accomplishments:

- worked with U.S. Attorneys' offices in Michigan, recoveries in the Medicare Secondary Payer program rose dramatically in FY 1997, to almost \$9 million.
- assisted in recovering \$8.5 million from a provider for an overpayment relating to a closed cost year and the discovery of improper, fraudulent cost accounting methods.
- reviewed notices sent to providers suspending payments based on suspected Medicare fraud, which has led to systemic changes to the notices decreasing their vulnerability to successful legal challenges.
- pursued recovering approximately \$1.8 million in overpayments to a bankrupt Medicare-participating home health agency.

These are just a few examples of OGC's accomplishments under the HCFAC program for 1997. It is expected that the activities of the OGC will continue and expand as the program matures.

## Administration on Aging

The Administration on Aging (AoA), with its vast network of state and area agencies on aging and community-based services, serves as a partner with the HHS/OIG and HCFA in the long-term federal effort to fight and prevent fraud and abuse in the Medicare and Medicaid programs.

In 1997, the AoA was allocated \$1.1 million under the Program. These funds were used to train and educate both paid and volunteer staff in the aging network, especially those associated with Older American Act programs and services, such as long-term care ombudsman, to recognize and report potential practices and patterns of fraud and abuse in the Medicare and Medicaid programs. Additionally, AoA and its network agencies engaged in outreach and educational activities to inform and empower older persons, their families and their communities to recognize and report fraudulent and abusive situations and to prevent or minimize victimization by such behavior.

HCFAC funding resulted in the following AoA accomplishments:

- awarded 15 cooperative agreements to state units on aging to support education, training and outreach efforts to help aging network staff and volunteers to recognize and report health care fraud and abuse;
- planned and convened in collaboration with HHS/OIG and HCFA a two-day national meeting in September, 1997 for an orientation to health care anti-fraud and abuse for 116 representatives of state units on aging and other aging network agencies;
- tested targeted community outreach models in New York City, Los Angeles, suburban Chicago, IL, and Central Florida where several thousand of older persons were trained to recognize and report health care fraud and empowered to minimize becoming victims of such practices;
- in collaboration with HHS/OIG and the Assistant Secretary for Planning and Evaluation initiated plans to evaluate the effectiveness of aging network staff and agencies to recognize and report Medicare fraud and abuse;
- conducted with HHS/OIG and HCFA, 10 health care anti-fraud and abuse workshops for approximately 535 aging service professionals at 8 major national and regional conferences of aging network agencies; and
- contracted with the University of Louisville to design software enhancements to report and track fraud and abuse referrals from state long-term care ombudsmen.

The training and outreach activities have already resulted in significant referrals to the HHS/OIG hotline and other investigative and enforcement agencies leading to various sanctions, recoupments and prosecutions.

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## FUNDING FOR DEPARTMENT OF JUSTICE

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### United States Attorneys

Health care fraud involves many different types of schemes that defraud Medicare, Medicaid, Department of Veterans Affairs, or other insurers or providers. The fraudulent activity may include double billing schemes, kickbacks, billing for unnecessary or unperformed tests, or may be related to the quality of the medical care provided. Working closely with the Department of Justice Civil and Criminal Divisions, United States Attorneys' offices (USAOs) criminally and civilly prosecute health care professionals, providers, and other specialized business entities who engage in health care fraud.

USAOs have established close ties with numerous federal and state law enforcement agencies who are involved in the prevention, evaluation, detection, and investigation of health care fraud. In addition to HHS/OIG and HCFA, these agencies include the State Medicaid Fraud Control Units (MFCUs); Inspectors General Offices of other Federal agencies; the Drug Enforcement Administration; DOD, DCIS; and the TRICARE Support Office in the Department of Defense (formerly CHAMPUS).

To assist in coordination and communication at local, state and national levels, each USAO has appointed both a criminal and civil health care fraud coordinator. Additionally, a Health Care Fraud Coordinator position has been established in the Executive Office for the United States Attorneys (EOUSA) to facilitate fraud enforcement efforts. Prior to the enactment of HIPAA, USAOs dedicated substantial resources to combating health care fraud. HIPAA allocations have supplemented these efforts.

Highlights of the first year of the Program include:

**Training:** The EOUSA's Office of Legal Education (OLE) is tasked with the responsibility for providing health care fraud training for USAO, and DOJ attorneys, investigators, and auditors. During 1997, OLE conducted a number of presentations and complete courses on health care fraud. Notably, OLE sponsored a conference in Basic Health Care Fraud Prosecution Team Training in July 1997. Many of the attendees were newly hired USAO personnel. Due in large part to overwhelming interest in basic team training, this program was repeated for those unable to attend the first course. The second course was held in September 1997. OLE plans to sponsor six health care fraud courses for Department prosecutors and support personnel in 1998.

Additionally, USAO attorneys, investigators and auditors participated in a number of non-OLE sponsored, multi-agency health care fraud training courses over the last year.

**Recruitment of Additional Prosecutors and Investigative Personnel:**

On January 6, 1997, the Attorney General announced that 167 new positions for health care fraud were authorized to be filled in USAOs. These included: 60 criminal Assistant United States Attorneys (AUSAs); 30 civil AUSAs; 23 paralegals; 30 auditor/investigators; 23 support positions, and a full-time Health Care Fraud Coordinator in the Legal Programs section of EOUSA.

**Accomplishments - Criminal Prosecutions**

The primary objective of criminal prosecution efforts is to ensure the integrity of our nation's health care programs and to punish and deter those who, through their fraudulent activities, abuse the health care system and the taxpayers.

Each time a criminal case is referred to a USAO from the FBI, HHS/OIG, or other enforcement agency, it is opened as a matter pending in the district. A case remains a matter until an indictment or information is filed or the case is declined for prosecution. Since 1996, criminal health care fraud matters have increased by approximately 13 percent. The number of defendants the United States has been investigating and referring for prosecution has also increased; since 1996, the number of defendants involved in criminal health care fraud matters has increased by approximately 15 percent.

CRIMINAL HEALTH CARE FRAUD MATTERS		
FISCAL YEAR	MATTERS	DEFENDANTS
1997	1,517	2,479
1996	1,346	2,151
1995	1,247	2,047

The increase in matters referred to USAOs has directly resulted in an increase in criminal health care fraud prosecutions filed. During 1997, criminal health care fraud prosecutions increased by approximately 15 percent over 1996. The number of defendants the USAOs have prosecuted has also dramatically increased, a 18 percent increase over 1996.

CRIMINAL HEALTH CARE FRAUD PROSECUTIONS FILED		
FISCAL YEAR	CASES	DEFENDANTS
1997	282	531
1996	246	450
1995	229	381

Health care fraud convictions include both guilty pleas and guilty verdicts. The Department has seen a tremendous increase in the number of convictions. During 1997, criminal health care fraud convictions reached a record high, a 22 percent increase over 1996. The number of defendants convicted increased 18 percent over 1996.

CRIMINAL HEALTH CARE FRAUD CONVICTIONS		
FISCAL YEAR	CASES	DEFENDANTS
1997	217	363
1996	177	307
1995	158	255

#### Accomplishments - Civil Cases

Civil health care fraud efforts constitute a major focus of Affirmative Civil Enforcement (ACE) activities. The ACE Program is a powerful legal tool used to help ensure that federal funds are recovered, federal laws are obeyed, and that violators provide compensation to the government for losses and damages they cause as a result of fraud, waste, and abuse. Civil health care fraud prosecutions ordinarily involve the United States utilizing the False Claims Act to recover damages and penalties against those who defraud the government, as well as the common law of fraud, payment by mistake, unjust enrichment and conversion. Additionally, in conjunction with a defendant committing a criminal health care fraud offense, the United States may file a civil proceeding using the Fraud Injunction Statute, to ensure assets traceable to such violation are available to repay those victims the defendant has defrauded.

CIVIL HEALTH CARE FRAUD MATTERS PENDING	
FISCAL YEAR	MATTERS
1997	4,010
1996	2,488
1995	1,406

Each time a civil case is referred to a USAO it is opened as a matter pending in the district. Civil health care fraud cases and matters are referred directly from federal or state investigative agencies. In addition, our efforts to combat health care fraud are aided by private persons known as "relators," who file suits on behalf of the Federal Government under the 1986 qui tam amendments to the False Claims Act and may be entitled to share in the recoveries resulting from these lawsuits.

A case remains a matter through settlement until the United States files a civil complaint, or intervenes in a qui tam complaint, in United States District Court. A large majority of civil health care fraud cases and matters are settled without a complaint ever being filed. 1997 civil health care fraud matters increased 61 percent over 1996.

CIVIL HEALTH CARE FRAUD CASES FILED	
FISCAL YEAR	CASES
1997	89
1996	90
1995	60

### Civil Division

Civil Division attorneys and AUSAs throughout the country working closely with the FBI, the HHS/OIG, the DOD/OIG, and other federal law enforcement agencies, as well as MFCUs, vigorously pursue civil remedies in health care fraud cases, and work on other projects that implicate the Civil Division's interests in the prosecution of health care fraud. A record setting number of new health care fraud cases and matters were initiated in 1997 -- 243 new actions is double the actions initiated in 1996, suggesting heightened enforcement emphasis for years to come.

A noteworthy success, highlighting cooperation between the Civil Division and the USAOs, was the \$319 million independent clinical laboratory settlement with Smithkline Beecham Clinical

Labs, which settled a range of allegations including kickbacks, billing for tests not performed, and fabrication of diagnosis codes. Other cases involving clinical laboratories billing for unnecessary blood tests produced sizeable civil settlements -- \$173 million from Laboratory Corporation of America and \$81 million from Damon Labs.

Also significant are the Department's settlements with Baptist Medical Center (\$17 million), Apria Healthcare Group, Inc. (\$1.65 million), and OrNda Healthcorp (\$12.6 million) for submitting claims to Medicare for goods and services provided pursuant to prohibited kickback arrangements.

Resources play an important role in promoting the expansion of health care fraud enforcement efforts. In 1997, the Civil Division received \$9,656,000 in funds from the Account for personnel and Automated Litigation Support (ALS). Authorization for an additional 33 positions was provided, including attorneys, analysts, auditors, paralegals, a training specialist, and a litigation support specialist.

The ability to effectively coordinate between the many organizations and locations that play a role in identifying and prosecuting health care fraud is crucial to successful enforcement efforts. Accordingly, an attorney was selected in 1997 to serve as the Civil Division's health care fraud coordinator. This attorney will work on improving the Civil Division's prosecution of health care fraud, and coordinating those efforts with other DOJ components, other law enforcement agencies, and the private sector.

Major progress was made in establishing ALS services for large-scale health care fraud cases in 1997. Many health care fraud cases involve a profusion of small fraudulent actions repeated systematically on a large number of patients at multiple locations throughout the country. ALS has been used successfully to create databases to identify patterns of activity among suspected offenders and calculate potential fraud and pinpoint those responsible for the fraud.

In 1997, funding from the Account also permitted the Civil Division to hire the services of statisticians, accountants and medical consultants to support health care fraud cases and investigations. Because health care fraud perpetrators are skilled at covering their tracks under mountains of claim forms and ledger sheets, accountants knowledgeable in the financial practices of large medical entities are critical to detecting the billing schemes of unscrupulous hospitals and other providers. Also important are ALS-provided statisticians who develop sampling plans and analyses for determining the pervasiveness and monetary value of the fraud. Medical consultants review patient files to determine if the services provided were medically necessary.

### **Federal Bureau of Investigation**

The FBI received \$3.6 million from the HCFAC for equipment, in addition to the \$47 million provided by HIPAA. (A description of the \$47 million is included in Appendix One). The equipment purchased with these funds was for enhancement of computer/technical and

surveillance inventories of multiple FBI field offices, and is dedicated for use in health care fraud investigations. The majority of the purchases were for laptop and desktop computers and enhanced computer software to assist in the complex and document intensive health care fraud matters. In addition, surveillance cameras and sophisticated consensual recording equipment was purchased. Further, several new Health Care Fraud Squads and multi-agency task forces were outfitted with standard investigative equipment.

### **Criminal Division**

The Fraud Section of the Criminal Division fashions and implements white collar crime policy and provides support to the Criminal Division, the Department and other federal agencies on white collar crime issues. The Fraud Section supports the USAOs with legal and investigative guidance and, in certain instances, provides trial attorneys to prosecute criminal fraud cases. For several years, a major focus of Fraud Section personnel and resources has been to investigate and prosecute fraud involving federal health care programs.

The Fraud Section has provided guidance to FBI agents, AUSAs and Criminal Division attorneys on criminal, civil and administrative tools to combat health care fraud through:

- updates on criminal, civil, administrative and regulatory efforts to combat health care fraud;
- memoranda summarizing the provisions of HIPAA distributed at the Health Care Fraud Working Group meetings and other training conferences, and updating the April 1995 Health Care Fraud manual to reflect the significant changes brought about by HIPAA distributed in the July and September 1997 training conferences on health care fraud;
- updates on significant appellate decisions concerning health care fraud prosecutions;
- development of guidance on authorized investigative demands. This provision empowers the Attorney General to issue investigative demands to obtain records for criminal investigations relating to federal criminal health care fraud offenses. These records are not subject to the constraints applicable to grand jury matters, and thus enhance the ability of USAOs to conduct parallel criminal and civil investigations.

### **Justice Management Division**

In order for DOJ to fulfill its obligations under the Program, additional resources were placed within the Justice Management Division, Debt Collection Management Staff. The duties of this office include: budget formulation, oversight and coordinating with the Office of Management and Budget and HCFA; development and data collection for the internal program evaluation; coordinating with HHS/OIG and the Department of the Treasury on the tracking of collections; coordinating with the General Accounting Office on required audits; and preparation and coordination of the annual report.

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## FUNDING FOR OTHER PARTNERS IN HEALTH CARE ENFORCEMENT AND OVERSIGHT

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Of the funds made available for 1997, up to \$3.5 million was set aside for enforcement activities by federal, state and local agencies (other than HHS and DOJ) that are currently involved in health care fraud and abuse detection and prevention activities. On March 26, 1997, HHS and DOJ jointly published a Notice of Availability of Funds inviting qualifying federal, state and local agencies to submit proposals to receive a portion of this money to fund projects or activities that promote the objectives of the Program. A total of 28 proposals were received and rated by a panel from HHS and DOJ. The panel recommended funding for 11 proposals (eight state governmental units, the District of Columbia, and two federal agencies) totaling \$1.55 million. The Secretary and the Attorney General adopted the recommendations of the panel, and funds were issued in July 1997. Following is a brief description of each of the funded proposals:

State of Alabama, Office of the Attorney General - \$232,700 - Funding was approved to purchase computer and transportation equipment, and provide training for investigators and auditors of the MFCU. Funds will also support a review of hospital reimbursement under Medicaid.

State of California, Office of the Attorney General, Bureau of Medi-Cal Fraud and Abuse  
State of New York, Office of the Attorney General, Medicaid Fraud Control Unit - \$300,000 - Funding was provided to develop a joint automated system for managing the tasks required to investigate and prosecute cases of health care fraud. Once developed, the system will be shared with other MFCUs.

State of Colorado, Department of Health Care Policy and Financing - \$213,334 - Two projects received funding: 1) a study to detect fraud and abuse by clients and/or providers who use multiple programs; and 2) a risk-adjusted methodology for setting Medicaid Health Maintenance Organization capitation rates.

Department of Defense, Inspector General - \$195,612 - Funding was approved to purchase, on behalf of DCIS, computer hardware and software to establish 12 on-line sites for direct access, downloading and analysis of data relating to the CHAMPUS program.

District of Columbia, Department of Human Services, Department of Health, and the Medical Assistance Administration - \$83,776 - Funding was provided to purchase computer software; to provide services and training for fraud and abuse detection; and to provide electronic communication between the Government Fraud Investigative Unit and the Medical Assistance Administration.

State of Nebraska, Department of Insurance - \$100,000 - Funding was provided to acquire a computerized data base to assist in health care enforcement and oversight efforts, as well as the equipment necessary to operate it and related training in its use.

State of North Carolina, Department of Insurance - \$28,932 - Funding was granted to provide professional and technical consultation, such as physicians and statistical analysts, for investigative agencies and prosecutorial authorities, in pursuit of health care fraud enforcement.

Commonwealth of Pennsylvania, Department of Public Welfare - \$112,315 - Funding was provided to acquire new software, hardware and training to enable the agency to produce more efficient and useful provider profiles to expedite case preparation and evaluation .

State of Tennessee, Department of Commerce and Insurance - \$121,700 - Funding was granted to coordinate health care activities among law enforcement agencies, and for public and industry outreach.

State of Wisconsin, Department of Justice - \$58,988 - Funding was granted for one full-time investigator, training materials and computer equipment for a beneficiary outreach program to identify health care fraud scams over the Internet.

Department of the Treasury, Internal Revenue Service, Criminal Investigative Division - \$107,000 - Funding was provided to conduct health care fraud training seminars, including training in managed care.

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## APPENDIX

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### Federal Bureau of Investigation Mandatory Funding

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*"There are hereby appropriated from the general fund of the United States Treasury and hereby appropriated to the Account for transfer to the Federal Bureau of Investigation to carry out the purposes described in subparagraph (C), to be available without further appropriation-- (I) for fiscal year 1997, \$47,000,000".*

Successful health care fraud enforcement cannot be achieved by any one agency alone. Investigations must be a cooperative effort if they are to be successful in combating the increasing problem of health care fraud. The FBI is involved in this cooperative effort. The FBI works many health care fraud cases on a joint basis with other federal agencies, including the HHS/OIG. These two federal agencies collaborate through attendance at health care fraud working groups, attend each others' training conferences, and have a liaison program between the two organizations. The FBI and the HHS/OIG share a common commitment to ending fragmented health care fraud enforcement.

In addition to providing new statutory tools to combat health care fraud, HIPAA specified mandatory funding to the FBI for health care fraud enforcement. The law provided the FBI with \$47 million in 1997 for its health care fraud efforts. The FBI used this funding, in large part, to fund an additional 46 agents and 31 support positions for health care fraud and to create several new dedicated Health Care Fraud squads. This increase in personnel resources increased the number of FBI agents addressing health care fraud in the fourth quarter of 1997 to the equivalent of 370 agents as compared to 112 in 1992. Funding is slated to increase incrementally until 2003, when it will reach \$114 million and remain at that level each year thereafter. With this additional funding, the FBI will continue to increase the number of agents committed to health care fraud investigations.

As the FBI has increased the number of agents assigned to health care fraud investigations, the caseload has increased dramatically from 591 cases in 1992, to 2,582 cases through 1997. The FBI caseload is divided between those health plans receiving government funds and those that are privately funded. Criminal health care fraud convictions resulting from FBI investigations have risen from 116 in 1992, to 485 in 1997\*. As the complexity and long-term nature of health care fraud investigations increase, the FBI anticipates that the number of investigations and convictions

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\*The FBI includes in its statistics convictions obtained through State prosecutions that resulted from an FBI investigation.

will begin to level off.

A considerable portion of the increased funding was utilized to support major health care fraud investigations. In addition, operational support has been provided for FBI national initiatives focusing on pharmaceutical diversion, chiropractic fraud, and medical clinic fraud. Further, the Health Care Fraud Unit, FBI Headquarters, supported individual Divisions' Health Care Fraud Squads with equipment and supplies to assist in numerous individual investigations.

The funding made available through HIPAA also made possible four Regional Training Conferences for FBI agents assigned to health care fraud investigations. These one-week training sessions sponsored by HCFA provided in-depth training on the Medicare Program to almost 300 agents. Other training sessions, including a session for the FBI's Financial Analysts and an FBI, DCIS, HHS/OIG Managers' Conference, were also made possible by HIPAA. Further, funding from HIPAA was utilized in Pharmacy Diversion Training and Cost Report Training to more than 100 FBI agents.

# GLOSSARY

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The Account - The Health Care Fraud and Abuse Control Account

ACE - Affirmative Civil Enforcement

ALS - Automated Litigation Support

AoA - Administration on Aging

AUSA - Assistant United States Attorney

CHAMPUS - Civilian Health and Medical Program of the Uniformed Services

DCIS - The Department of Defense, Defense Criminal Investigative Service

DOD - The Department of Defense

DOJ - The Department of Justice

DOL - The Department of Labor

DRG - Diagnosis Related Group

EOUSA - Executive Office for the United States Attorneys

FBI - Federal Bureau of Investigation

FI - Fiscal Intermediary

GAO - General Accounting Office

HCFA - Health Care Financing Administration

HCIS - HCFA Customer Information System

HHS - The Department of Health and Human Services

HI - Hospital Insurance Trust Fund

HIPAA, or the Act - The Health Insurance Portability and Accountability Act of 1996,  
P.L. 104-191

HIPDB - Healthcare Integrity and Protection Data Bank

HRSA - Health Resources and Services Administration

LANL - Los Alamos National Laboratory

MFCU - State Medicaid Fraud Control Unit

NPDB - National Practitioner Data Bank

NPRM - Notice of Proposed Rule Making

OGC - The Department of Health and Human Services, Office of the General Counsel

OIG - The Department of Health and Human Services, Office of Inspector General

OLE - Office of Legal Education, located within the Executive Office for the United States Attorneys

OPM - Office of Personnel Management

ORT - Operation Restore Trust

The Program - The Health Care Fraud and Abuse Control Program

RHHI - Regional Home Health Intermediary

USAO - United States Attorney's Office

U.S.C. - United States Code

VA - The Department of Veteran Affairs

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## COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES  
WASHINGTON, DC 20515

SUBCOMMITTEE ON HEALTH

December 15, 1997

 Cancer Drug File

The Honorable June Gibbs Brown  
Inspector General  
Department of Health and Human Services  
Washington, DC 20201

Dear Inspector General:

Congratulations on your excellent report, "Excessive Medicare Payments for Prescription Drugs" ( December 1997, OEI-03-97-00290). As the report indicates, if Congress had adopted the Administration's proposal to purchase drugs on the basis of actual acquisition cost rather than average wholesale price, Medicare and its beneficiaries would save over \$667 million a year.

While Congress passed legislation providing for the reimbursement of Medicare prescription drugs at 95% of the average wholesale price, your report states "We believe that the 5% discount that will soon be implemented is not a large enough decrease."

I believe it is worse than that! As your report makes clear, very few people actually buy drugs anywhere near the so-called average wholesale price (AWP). It is a fantasy price and paying 95% of a fantasy is still a fantasy. I have predicted that all that would happen is the AWP would increase roughly 5% and Medicare would be paying roughly the same amount per drug as before the passage of the Balanced Budget Act.

Those price increases may already be occurring, as manufacturers raise their AWP in order to give their customers the same high mark-up margins and thus the same extraordinary incentives to prescribe these highly profitable drugs.

Enclosed is a letter from a provider documenting the sudden rise in the wholesale

price of a generic drug known as Bleomycin Sulfate which is used in the treatment of cancer and HIV related diseases. I urge you to check the facts in this letter and report to the Congress on your findings. The provider asks, and I ask, that the letter be kept confidential. If the facts are right, it is proof that the 95% of AWP approach is a sad joke on the taxpayers and the Medicare program and that Congress must revisit this issue and pass an Actual Acquisition Cost law.

As you can see from the letter, Pharmacia/Upjohn has a generic version of Bristol-Myers Squibb's bleomycin sulfate. Starting in December, it appears that this generic is now costing more than the original brand name drug cost in 1997, thus driving up Medicare's costs (since Medicare's AWP is based on the generic price). I find it absurd that a generic would cost more than the product of the company that originally made the drug.

As you can further see from the letter, it is reported that the December 1, 1997 Red Book (which lists the AWPs) for bleomycin sulfate have increased about 6% over the 1997 Red Book listing, thus wiping out any savings Medicare might get by going to 95% of AWP. Further, the true price to the customer continues to be about 2/3rds the AWP prices. In fact, according to the data provided by this provider, the spread or the incentive to use the Pharmacia/Upjohn product actually increased \$4 between 1997 and 1998, giving the buyer a profit of \$250.91 on 30 units of bleomycin sulfate.

Is the data in this letter accurate? Are other pharmaceutical companies starting to make the same price adjustments to evade the impact of the 1997 law? Your early response to this inquiry will help greatly in re-opening this debate.

Sincerely,

Pete Stark  
Ranking Member  
Subcommittee on Health

Encl.



DEC 11 1997

TO: James C. Murr (OMB)

FROM: Margaret A. Hamburg, M.D. *M.A.H.*  
Assistant Secretary for Planning and Evaluation

SUBJECT: Additional DHHS Legislative Proposals

Attached are additional legislative proposals that the Department of Health and Human Services wishes to pursue during the second session of the 105<sup>th</sup> Congress. These supplement an initial set of proposals sent to you on September 12. Please note that, in addition to the proposals that we have submitted to OMB since September, we will continue to work for enactment of the proposals approved by OMB and sent to Congress this past spring.

Your attention to expediting the review and approval of our proposals is appreciated.

Attachment

HEALTH CARE FINANCING ADMINISTRATION  
FISCAL YEAR 1999 LEGISLATIVE PROPOSAL

Debarred Individuals

Prohibit Affiliations with Individuals Debarred by Federal Agencies.

Current Law: Under section 1902(a)(39) of the Act, State agencies must exclude certain individuals and entities from participation in the Medicaid program (as outlined in Section 1128 and 1128A). These individuals are excluded from participation only as a provider of service, not as an employee of a provider of services.

Proposal: Require Medicaid providers to assure that they:

- (1) have no person, as described below, as a director, officer, partner, or person with beneficial ownership of more than 5 percent of the entity, or
- (2) have no employment, consulting, or other agreement with a person as described below for the provision of items and services that are significant and material to the entity's obligations under its provider agreement with the State.

Such a person is one who:

- (1) is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulations or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing that order; or
- (2) is an affiliate of a person described in (1) above.

Rationale: Current law does not prevent such individuals from participating in the Medicaid program. State agencies indicate that persons excluded from Medicaid as providers for fraudulent activities may, and often do, find employment in a hospital, clinic, or pharmacy. This loophole weakens the program's ability to take all necessary steps to protect beneficiaries and the public against fraud in the Medicaid program.

Effect on Beneficiaries: Negligible. However, providers would have new responsibilities.

Federalism Impact: None.

Cost: To be determined.

**Effective Date: October 1, 1998.**

HEALTH CARE FINANCING ADMINISTRATION  
FISCAL YEAR 1999 LEGISLATIVE PROPOSAL

Surety Bonds -- Transportation

Require a Surety Bond For Providers of Non-emergency Medical Transportation.

Current Law: There is no surety bond requirement for non-emergency medical transportation (NMT).

Proposal: Require Medicaid providers of non-emergency medical transportation to post a surety bond. IHS and IHS-funded tribal and urban Indian health providers would be exempt. States would be permitted to make an exception for program volunteers who are paid only mileage for their efforts in cases where access would become a problem

Rationale: Non-emergency medical transportation (NMT) has grown from a \$100 million to a \$1 billion industry in the past five years. This proposal is designed both to provide operational standards to the NMT industry and to eliminate non-creditworthy providers.

This proposal would extend the surety bond requirement in the Balanced Budget Act of 1997 that applied to home health agencies and DME suppliers to providers of non-emergency medical transportation.

Effect on Beneficiaries: There would be a negligible effect on beneficiaries, although bond requirements could affect beneficiary access in areas with few participating providers.

Federalism Impact: This proposal is a mandate. While States may impose such a requirement on providers under current Federal law -- and some have done so -- States have asked for this authority in Federal law to help them overcome local political hurdles to the imposition of a surety bond requirement on providers.

Cost: Savings to be determined. Savings result in part when bonding agencies refuse to bond transportation providers that are not creditworthy -- those most likely go out of business and to thereby cause uncollectible overpayments. Savings also result from States being able to collect overpayments from bonding agencies when providers that they have bonded go out of business. Savings from recoveries outweigh the cost, if any, to the States since States do not automatically pay providers more or in proportion to the amount of increases in provider costs. Also, the cost of bonding to each provider will, in almost every instance, be too small to cause a noticeable increase in their cost of doing business.

Effective Date: January 1, 1999.

HEALTH CARE FINANCING ADMINISTRATION  
FISCAL YEAR 1999 LEGISLATIVE PROPOSAL

Surety Bonds -- Clinic Operators

Require a Surety Bond For Non-physician Clinic Operators.

Current Law: There is no surety bond requirement for non-physician clinic operators (NCO).

Proposal: Establish a surety bond requirement for non-physician clinic operators (NCO). IHS, and IHS-funded tribal and urban Indian health providers would be exempt.

Rationale: This proposal is designed both to provide operational standards to the non-physician clinic operator (NCO) industry, and to eliminate non-creditworthy NCO providers.

This proposal would extend the surety bond requirement in the Balanced Budget Act of 1997 that applied to home health agencies and DME suppliers to non-physician clinic operators.

Effect on Beneficiaries: There would be a negligible effect on beneficiaries, although bond requirements could affect beneficiary access in areas with few participating providers.

Federalism Impact: This proposal is a mandate. While States may impose such a requirement on providers under current Federal law -- and some have done so -- States have asked for this authority in Federal law to help them overcome local political hurdles to the imposition of a surety bond requirement on providers.

Cost: Savings to be determined. Savings result in part when bonding agencies refuse to bond clinic operators that are not creditworthy -- those most likely go out of business and to thereby cause uncollectible overpayments. Savings also result from States being able to collect overpayments from bonding agencies when providers that they have bonded go out of business. Savings from recoveries outweigh the cost, if any, to the States since States do not automatically pay providers more or in proportion to the amount of increases in provider costs. Also, the cost of bonding to each provider would, in almost every instance, be too small to cause a noticeable increase in their cost of doing business.

Effective Date: January 1, 1999.

HEALTH CARE FINANCING ADMINISTRATION  
FISCAL YEAR 1999 LEGISLATIVE PROPOSAL

Surety Bonds -- Pharmacies

Surety Bond Requirement For Pharmacies.

Current Law: There is no surety bond requirement for pharmacies.

Proposal: Give States the option of requiring pharmacies to post a surety bond to participate in Medicaid. Provide States the flexibility to: (1) use this option as a sanction; (2) set a threshold, e.g., only pharmacies that receive more than \$200,000 per year from Medicaid would be required to have surety bonds; and (3) target the use of a surety bond (i.e., by geographic location or claims volume). IHS and IHS-funded tribal and urban Indian health providers would be excepted.

Rationale: This proposal is designed to allow the States a mechanism to eliminate fraudulent providers that accumulate significant program overpayments and then go out of business or leave the country, resulting in uncollectible overpayments. This occurs because many fraudulent providers, particularly in urban areas, operate at very low financial margins and do a majority of their business with Medicaid. Once an overpayment is discovered, most States immediately cease reimbursement to the provider, thus cutting off the provider's revenue stream.

This proposal should not be mandatory since some States have State pharmacy licensing boards or other licensing requirements which would prevent most "on the edge" providers from enrolling in the program. Additionally, a mandate could create access problems for some States with large rural service areas.

Effect on Beneficiaries: Negligible, although in specific localities served primarily by financially marginal providers, a reduction in the number of participating pharmacies could have a negative effect on beneficiary access to pharmacy services.

Federalism Impact: Federal legislation which allows States the flexibility of implementing surety bonds would greatly expedite the implementation process for States that decide to take advantage of this option. The need to get approval from their State legislatures to implement this proposal would no longer be an obstacle to implementing surety bonds.

Cost: Savings to be determined. Savings result in part when bonding agencies refuse to bond pharmacies that are not creditworthy -- those most likely go out of business and to thereby cause uncollectible overpayments. Savings also result from States being able to collect overpayments from bonding agencies when pharmacies that they have bonded go out of business. Savings from recoveries outweigh the cost, if any, to the States, since States do not automatically pay providers

more or in proportion to the amount of increases in provider costs. Also, the cost of bonding to each provider will, in almost every instance, be too small to cause a noticeable increase in their cost of doing business.

Effective Date: January 1, 1999.

HEALTH CARE FINANCING ADMINISTRATION  
FISCAL YEAR 1999 LEGISLATIVE PROPOSAL

Medicaid Beneficiary Eligibility

Permit States to Limit, Restrict, or Suspend the Eligibility of a Medicaid Beneficiary for Reasons Other Than the Conviction of a Specific Listed Federal Crime.

**Current Law:** Section 1128B(a) of the Social Security Act permits States to limit, restrict, or suspend the eligibility of a Medicaid beneficiary for a period not exceeding one year if that individual has been convicted of the specific Federal crimes listed in the statute. These Federal crimes include false statements to obtain Medicaid enrollment or services, converting benefits or payment to other than the enrollee, and fraudulently securing benefits or payment in a greater amount or quantity than authorized.

**Proposal:** Permit States to limit, restrict, or suspend the eligibility of beneficiaries for other reasons besides the specific listed Federal crimes, e.g., convictions in State courts; for similar offences that are in violation of State law.

**Rationale:** This proposed change to existing Federal statute would provide States with flexibility to use State courts to prosecute recipient fraudulent or abusive practices with the objective of limiting/restricting services to recipients or suspending eligibility. Currently, the only way a State can suspend eligibility is to seek prosecution in a Federal court. In many cases, Federal prosecutors are reluctant to prosecute individuals involved in fraudulent/abusive practices because they may consider that they have more significant cases to prosecute. Allowing prosecution of these cases at the State level would relieve pressure to prosecute at the Federal level and provide the States with better control over fraudulent/abusive practices occurring within their State Medicaid program. If State law, in existence or to be developed, were allowed to operate in conjunction with Federal statute, there would be an additional level of jurisdiction to prosecute recipient fraud and abuse.

**Effect on Beneficiaries:** The only beneficiaries who would be affected would be those who are involved in fraudulent or abusive practices. Medicaid beneficiaries affected by this proposal would still be able to obtain needed medical care, with prior authorization by the State, where a State restricted, rather than suspended, his or her eligibility. Because the Medicaid program is operated by the various States, they have a direct interest in ensuring that only eligible beneficiaries are enrolled in the program.

**Cost:** Significant costs could be avoided by providing more ways to ensure that those who engage in fraud or abusive practices against the Medicaid program are prevented from doing so or are prosecuted.

HEALTH CARE FINANCING ADMINISTRATION  
FISCAL YEAR 1999 LEGISLATIVE PROPOSAL

Fraud and Abuse Overpayments

Federal Recovery of Medicaid Overpayments from States.

Current Law: Section 1903(d)(2)(A) of the Social Security Act requires that the Federal share of any overpayments reported by the State be immediately refunded through the grant award process. In general, Federal regulations give States 60 days following discovery that it has overpaid a provider to refund the Federal share of the overpayment. However, Federal regulations also allow States a longer period of time to repay the Federal share, described in 42 CFR 433.318, in the case of overpayments made to providers that file for bankruptcy or that go out of business within the 60-day period. Current law does not provide such longer periods of time for repayment of the Federal share in cases of provider fraud.

Proposal: Provide that when a State discovers an overpayment and determines it to be attributable to fraud, the State refund the Federal overpayment in the quarter in which a recovery is made, regardless of when the overpayment is discovered. Such overpayments determined to be attributable to fraud would only include overpayments investigated by either the State agency program integrity unit or the Medicaid Fraud Control unit.

Rationale: Currently, States are deterred from seeking recovery against fraudulent providers and related parties that may be judgment-proof or that may flee the jurisdiction. They are reluctant to risk discovering such overpayments, and having to refund the Federal share before the end of the 60 day period, because there is a substantial possibility that they will be unable to actually recover anything from the fraudulent provider. In linking repayment of the Federal share to actual recovery -- instead of mere discovery -- the proposed exception recognizes that fiscal prudence in overpayments in these kinds of cases may be best served by more lenient time frames.

Effect on Beneficiaries: Negligible.

Federalism Impact: None.

Cost: To be determined.

Effective Date: October 1, 1998.

HEALTH CARE FINANCING ADMINISTRATION  
FISCAL YEAR 1999 LEGISLATIVE PROPOSAL

Promote Competition for Medicare Contracts

Increase the Secretary's Flexibility in Contracting for Medicare Claims Processing and Payment Functions.

**Current Law:** Section 1816 authorizes the Secretary to establish a network of Medicare fiscal intermediaries by entering into agreements with public or private organizations nominated by Part A providers. All Medicare intermediaries currently nominated by Part A providers are insurance companies. Section 1842 authorizes the Secretary to enter into contracts with health insuring organizations, called carriers, for the administration of benefits under Part B of the program.

**Proposal:** Allow the Secretary to contract competitively with any qualified entity, including, but not limited to, insurance companies, to perform any one or more of the program functions currently performed by FIs or carriers. To compensate Medicare Part A providers for giving up the nomination right, providers would be able to choose every five years from among three fiscal intermediaries made available by the Secretary. One of the choices would be required to be located in the same general geographic area as the provider. Chain providers with a common owner would be able to select one intermediary to service all of its' providers nationwide. The Secretary also could solicit comments from providers in evaluating the fiscal intermediaries during the review process. Finally, this proposal would replace the current legislative requirement that the Secretary's evaluation process for Medicare intermediaries and carriers be promulgated through the Federal Register with authority more in keeping with standard government contracting procedures.

**Rationale:** This would replace the provider nomination provision that constrains the Secretary's authority to contract freely with an alternative mechanism that still guarantees providers some choice with respect to which entity serves as their fiscal intermediary for claims processing and payment. Under current law, the Secretary may only choose intermediaries\*from among the insurance companies nominated by Part A providers. These entities are then given jurisdictions, usually of one or more States, in which to operate. This effectively gives Medicare few choices in trying to find the most efficient entity to handle a particular service. This proposal would promote competition, give the Secretary increased flexibility in the contracting process, and give the Secretary authority to contract on a best-value basis. For instance, under this authority, the Secretary could take aggressive action with contractors to ensure full compliance with the Millennium initiative. This flexibility will be an essential tool in managing contractors to ensure that their computer systems are modified to continue processing claims in the year 2000. Otherwise, Medicare is limited in what can be done to ensure compliance.

The Secretary needs increased flexibility to competitively contract for a function that an intermediary or carrier is not performing well without being forced to compete other functions that are being performed well by the existing FI or carrier. In addition, this flexibility also would help Medicare deal with a changing health care environment. For example, many insurers have recently purchased HMOs or other providers. If a Medicare contractor purchases a provider in its service area, that can create a potential conflict of interest. In those cases, Medicare could look to other candidates to handle claims processing and payment functions. It is intended that this proposal will build on the flexibility given the Secretary through the Medicare Integrity Program (MIP) provisions that have given the Secretary increased tools to combat fraud and abuse.

**Effect on Beneficiaries:** Providing the Secretary with flexibility to contract for Medicare functions on a "best-value" basis would enable the Secretary to keep the same contractor or choose a better contractor. This would ensure that beneficiaries receive equal or better customer service than in the current environment.

**Cost:** Providing the Secretary with authority to contract on a competitive basis would likely result in lower administrative costs. Actual savings would depend on such factors as the pace and scope of future procurement actions.

**Effective Date:** Upon enactment.

HEALTH CARE FINANCING ADMINISTRATION  
FISCAL YEAR 1999 LEGISLATIVE PROPOSAL

Increase Contracting Flexibility

Allow the Secretary to Contract for Medicare Functions on Any Basis Permitted by the Federal Acquisition Regulations.

**Current Law:** Sections 1816 and 1842 of the Social Security Act authorize the Secretary to enter into agreements with fiscal intermediaries (FIs) and contracts with carriers. These agreements/contracts must be on a cost reimbursement basis. Contracting on an other-than-cost basis may only be done under Medicare experimental authority (Social Security Amendments of 1972) or when the Secretary and the contractor can mutually yet non-competitively negotiate another arrangement. (Social Security Act Amendments of 1994)

**Proposal:** Permit the Secretary to determine, on a procurement-by-procurement basis, the most appropriate contract payment arrangement.

**Rationale:** This proposal would allow the Secretary to determine the appropriate type of payment for the contract on a case-by-case basis. Some procurements involve easily defined functions that can be reimbursed on a fixed-price basis, while there are other functions where incentives might be added to a contract because quality is of the utmost concern.

The Federal Acquisition Regulations (FAR) offer more flexibility than current Medicare law in regard to paying contractors for their services for two basic classes of contracts -- fixed price and cost -- with various types of allowable fees depending on the situation. The potential result of this increased flexibility would not only be savings to the Medicare program, but also an increase in the efficiency and quality of Medicare contractors. For instance, the Secretary could design contracts with selective incentives to achieve cost or quality objectives based on the government's best interest at the time the contract is initiated. HCFA's experiences with innovative contract arrangements under an experimental authority granted by the Social Security Amendments of 1972 have proven that contract reimbursement on an other-than-cost basis can be more effective than traditional cost contracts in promoting efficient performance of services.

**Effect on Beneficiaries:** The potential savings and efficiencies achieved from this proposal would help improve the processing of claims and Medicare customer service functions such as appeals. This would improve overall Medicare operations and provide better quality service to Medicare beneficiaries.

**Cost:** Flexibility to utilize fixed price-type contracts and other contract types when circumstances are appropriate should result in future administrative cost savings. Actual savings would be dependent on factors such as the pace and scope of future procurement actions.

**Effective Date: Upon enactment.**

HEALTH CARE FINANCING ADMINISTRATION  
FISCAL YEAR 1999 LEGISLATIVE PROPOSAL

Contractor Termination Requirements

Eliminate the Special Provisions for Terminations of Contracts with Fiscal Intermediaries and Carriers.

Current Law: Section 1816(g)(2) of the Social Security Act gives the Secretary authority to terminate a Medicare fiscal intermediary agreement only after the contractor is furnished notice and provided an opportunity to request a public hearing. Further, the termination is contingent on a finding that the Medicare intermediary has not met the standards, criteria, and procedures promulgated by the Secretary in accordance with Section 1816(f), and with other standards of proof spelled out in 1816(g)(2). Section 1814(b)(5) of the Social Security Act establishes a similar requirement for notice and hearing with respect to the termination of Medicare carrier contracts.

Proposal: Eliminate the special provisions for terminations of contracts with fiscal intermediaries and carriers. This would ensure that Medicare was contracting on a basis that is consistent with the actions of other government agencies under the Federal Acquisition Regulations (FAR). Other government contractors do not have hearing rights before termination.

Rationale: This proposal provides the Secretary with greater program flexibility by bringing Medicare contractors under the same legal framework as other government contractors. The elimination of the right to a hearing would not effect the contractors' other legal remedies, but would give the Secretary greater administrative flexibility in replacing poor-performing contractors promptly. This would remove an anachronistic, non-standard aspect of the Medicare contracting process.

Effect on Beneficiaries: None.

Cost: To be determined.

Effective Date: The first contract renewal date after enactment.

HEALTH CARE FINANCING ADMINISTRATION  
FISCAL YEAR 1999 LEGISLATIVE PROPOSAL

Streamline Contracting Administration

Authorize the Secretary to Execute Combined Part A and Part B Contracts.

Current Law: Under current law, the Secretary has the authority to enter into agreements with entities, called fiscal intermediaries, nominated by providers participating in the Part A program (§1816 of the Social Security Act) and to enter into contracts with health insuring organizations, called carriers, to process Part B claims (§1842 of the Social Security Act).

Proposal: Authorize the Secretary to enter into combined Part A and Part B contracts.

Rationale: Medicare would have the flexibility to contract for the similar functions now performed by intermediaries and carriers through a combined contract. There are 17 States in which the company that holds the Medicare carrier contract also serves as the Medicare intermediary. This results in some administrative overlap. This proposal builds on the flexibility created in the MIP program to contract out some important functions, such as audits of cost reports or medical review. This proposal would give the Secretary the necessary authority to take advantage of potential efficiencies with those contractors acting as both intermediaries and carriers.

Effect on Beneficiaries: Beneficiary claims would be handled more consistently. Outreach to beneficiaries on Medicare Part A and Part B issues could be combined, thereby increasing efficiency, which would allow expansion of these activities.

Cost: To be determined. There should be some long-term savings by eliminating payment for duplicative staff and the overhead associated with those activities. There also would be internal administrative savings from limiting the number of budgets and contracts that need to be negotiated.

Effective Date: Upon enactment.

HEALTH CARE FINANCING ADMINISTRATION  
FISCAL YEAR 1999 LEGISLATIVE PROPOSAL

Rural Health Clinic Services

Provide for a Prospective Payment System for rural health clinic services.

Current Law: Congress established the Rural Health Clinic program in 1977 and provided for reasonable cost reimbursement for RHC services (sections 1833 and 1833(f) of the Social Security Act). Implementing regulations specify that payment be made on an all-inclusive per-visit basis. Currently there is an overall payment limit on the all-inclusive rate per visit for rural health clinics of \$57.77.

Proposal: Authorize the Secretary to develop and implement, by no later than January 1, 2002, a prospective payment system for rural health clinic services. In developing the system, the Secretary would:

- o be authorized to make appropriate adjustments for excessive utilization of RHC services;
- o establish initial payment levels so that projected payments under the system in the first year of implementation would equal payments that would otherwise have been made (after accounting for the adjustments described above);
- o provide for annual updates to prospective rates; and
- o establish beneficiary coinsurance equal to 20 percent of the prospective rate.

Rationale: When the RHC program was first implemented, HCFA established rules requiring that payment for RHC services be made on a per-visit basis. An upper payment limit was subsequently enacted into law. Many RHCs are now paid at the upper payment limit. A prospective payment system would simplify an increasingly complicated payment system and eliminate the need for intermediaries to process and audit RHC cost reports.

Effect on Beneficiaries: None.

Cost: Negligible.

HEALTH CARE FINANCING ADMINISTRATION  
FISCAL YEAR 1999 LEGISLATIVE PROPOSAL

Expand Certain Medicare+Choice Intermediate Sanctions and Civil Monetary Penalties to Apply to Plan Contracting Providers or Other Individuals or Entities Affiliated With the Plan.

**Current Law:** Under sections 1876(I)(1) and 1857(c)(2) of the Act, the Secretary may terminate a Medicare managed care contract at any time if the organization is found to have failed substantially to carry out the terms and requirements of the contract.

Sections 1876(I)(6) and 1857(g) establish our authority to impose certain intermediate sanctions under certain circumstances. Intermediate sanctions include prohibiting the plan from engaging in any marketing or enrollment activities, and banning payments for new enrollment. Sanctionable activities include failure to provide medically necessary items and services, and certain health screening activities (e.g., denying or discouraging enrollment or refusing to re-enroll persons based on their health care needs). Civil monetary penalties are also authorized under these sections.

**Proposal:** Expand HCFA's explicit authority to permit the imposition of intermediate sanctions and/or civil monetary penalties when we determine that an individual or entity with a financial arrangement with the plan has:

- o failed to provide medically necessary services,
- o made false statements to induce a beneficiary to enroll or not enroll in a plan, or
- o excluded potential beneficiaries through engaging in health screening.

Intermediate sanctions would include revocation of a provider's Medicare certification, disbarment from the program for a specified period of time, and mandatory inclusion in the HRSA "Adverse Action" database. The civil monetary penalty authority would be expanded to authorize fines of up to \$100,000 for any party that is found to have benefitted financially because of a fraudulent action as described above. In addition, Medicare+Choice plans would be prohibited from hiring, or contracting with, any individual who has been subject to intermediate sanctions and/or civil monetary penalties.

**Rationale:** Currently, the program only has the authority to penalize contracting organizations when a provider fails to provide covered items and services, or when a plan marketing agent screens potential enrollees for health problems. This proposal would expand current beneficiary protections by allowing the program to impose separate penalties against a contracting managed care plan's providers, contractors, or agents, for marketing and enrollment abuses, or when enrolled beneficiaries fail to receive medically necessary care. These new penalties might be in

lieu of, or in addition to, any penalties assessed against the plan directly.

Examples of situations where the program might choose to use this new authority include: (1) If an individual physician or hospital inappropriately steers beneficiaries to enroll or not to enroll in a specific plan; (2) if a provider inappropriately encourages a beneficiary to choose fee-for-service or managed care based on health needs; (3) if a provider inappropriately encourages a beneficiary to make a specific plan choice based on the financial reward to the provider; or (4) if a marketing agent makes false statements or fails to provide relevant information in order to induce a beneficiary to enroll in a particular plan. The program would not use this authority to penalize providers or individuals who provide general information about specific health plan options, such as whether or not the provider is part of a plan network.

Effect of Beneficiaries: All Medicare beneficiaries would have additional protections against infringements on their ability to make appropriate health plan choices.

Cost: Negligible.

HEALTH CARE FINANCING ADMINISTRATION  
FISCAL YEAR 1999 LEGISLATIVE PROPOSAL

Liability of Physicians On-call for Emergency Services at Hospitals with Specialized Capabilities.

**Current Law:** The anti-dumping law was established over a decade ago to prevent hospitals and physicians from refusing care to individuals with emergency medical conditions, even if they were unable to pay for medical services or were without health insurance coverage. The anti-dumping law currently prohibits a hospital (Hospital A) from turning away individuals without at least an appropriate medical screening to see if the individual has an emergency medical condition. If the individual has a medical emergency, the hospital must either stabilize that emergency condition or provide for an appropriate transfer (as defined under section 1867 of the Act). An appropriate transfer includes situations where the health benefits outweigh the risks involved in transferring an individual to a hospital with specialized capabilities or facilities (e.g., a burn, trauma, or neonatal intensive care unit). The hospital on the receiving end (Hospital B) must accept such a transfer if it has both the capability and capacity to treat the individual. Hospitals that violate these requirements are subject to civil money penalties of up to \$50,000 for each violation. In addition to the mandate on hospitals, physicians both at and/or on-call to Hospital A who are responsible for the examination, treatment, or transfer of an individual, are subject to civil monetary penalties of up to \$50,000 if they negligently violate an anti-dumping requirement. An on-call physician can also be subject to a civil monetary penalty if he/she refuses to go to the hospital to conduct a screening exam or to stabilize an emergency medical condition. However, if a physician, acting on behalf of Hospital B, refuses an appropriate transfer or he/she literally refuses to go to Hospital B, only Hospital B is subject to civil monetary penalties. The on-call physician at Hospital B is not subject to a civil monetary penalty for this negligent violation of the statute.

**Proposal:** Make a physician who is on-call at a hospital with specialized capabilities or facilities also subject to sanction, under the anti-dumping statute, if he/she rejects a request for an appropriate transfer (acting on behalf of Hospital B) or if he/she refuses to go to the hospital in response to a call for a request to transfer.

**Rationale:** The current version of the anti-dumping law prohibits hospitals with specialized capabilities and facilities from refusing appropriate patient transfers; however, physicians who work at and/or are on-call to these hospitals, and are often the individuals who refuse appropriate transfers, are not subject to penalties under the anti-dumping statute. Just as physicians who are affiliated with hospital emergency rooms can be held accountable in dumping cases for negligent violations of the statute, the anti-dumping law should also apply to physicians affiliated with specialized hospitals. Therefore, the law should be clarified that the on-call physician at Hospital B must come in to see a patient being transferred to Hospital B by Hospital A, since if he or she does not agree to come in, there would be no specialist to see the patient at Hospital B and the

appropriate transfer could not occur. Also, while acting on behalf of Hospital B, if the on-call physician were to refuse a request for an appropriate transfer to Hospital B, this would be in violation of the statute.

Effect on Beneficiaries: All patients would enjoy Increased protection under the anti-dumping law.

Cost: Negligible.

HEALTH CARE FINANCING ADMINISTRATION  
FISCAL YEAR 1999 LEGISLATIVE PROPOSAL

Medicare Physician Fee Schedule

Require that Physicians Perform the Work Components of the Physicians' Professional Services Paid Under the Medicare Physician Fee Schedule.

**Current Law:** Currently, when providing services to patients who are not receiving hospital or SNF benefits, physicians are permitted to delegate the physician work component of their services to their non-physician employees, such as nurses, medical assistants, physician assistants, etc. Physician work is identified as a separate and unique component under the Medicare physician fee schedule and Medicare pays for that work through a distinct portion of its payment to physicians. Medicare has identified those work components and valued them with the assistance of the physician community. Inherent in the statute is the assumption that physician work is to be done by physicians, since, under the law, the physician work component reflects physician time and intensity associated with rendering a service. (Section 1848(c)(1)(A) of the Social Security Act) Despite this assumption, some physicians are delegating their work to their employees and when this occurs, the services are covered as services "incident to" physicians' services and are paid by Medicare as though the physician actually performed the physician's work ( i.e., at the physician payment rate). Some of the physician employees to whom this work is delegated are themselves recognized practitioners under the Medicare program. This is the case, for example, for physician assistants, nurse practitioners, and clinical nurse specialists. However, unlike the "incident to" situation, when Medicare pays such non-physician practitioners under their practitioner benefits, it pays them at 85% of the physician rate. (For patients receiving hospital and SNF benefits, physicians and other recognized practitioners already have to personally perform the physician/practitioner "work" associated with a service in order to be paid for a physician or other practitioner service by Medicare. This is because there are no physician/practitioner "incident to" staff to whom such work can be delegated in those settings. Instead, the work of such staff is bundled into the hospital or SNF service and paid through the Medicare hospital or SNF payment.)

**Proposal:** Provide that Medicare would not pay for services with physician work components at the physician payment rate, if the work is not personally performed by a physician. If the work is personally performed by another covered practitioner, such as a physician assistant or nurse practitioner, Medicare would pay at the payment rate applicable to that practitioner. If the work is performed by physician employees who have no Medicare practitioner status, no Medicare payment would be made for the service. Provide that Medicare beneficiaries cannot be billed for services not paid by Medicare because the work was performed by a physician employee without Medicare practitioner status.

**Rationale:** The current practice of some physicians delegating their physician work to their employees has resulted in:

- o Medicare payment of physician payment rates for services rendered by physician assistants, nurse practitioners, and clinical nurse specialists, who have coverage of their own under Medicare at lower rates (i.e., the use of "incident to" coverage circumvents these lower payment rates established by Congress under these other specified benefits);
- o Medicare payment of physician payment rates for services rendered by individuals who have no practitioner coverage under Medicare -- raising not only budgetary concerns, but also serious health and quality concerns (e.g., one OIG office reports unlicensed technicians reading EKGs, office nurses being sent to provide treatments to nursing home patients, and psychotherapy being provided by untrained and unlicensed personnel -- all involving physicians delegating their work to their employees under "incident to" coverage);
- o Medicare payment of physician payment rates for services rendered by limited license "physicians" such as chiropractors who provide services as incident to employees of MDs and DOs which go beyond the scope of the services for which Medicare recognizes their "physician" status (e.g., as incident to employees of MDs and DOs, chiropractors are performing physical medicine and rehabilitation procedures beyond the service for which Medicare will pay them as physicians -- i.e., beyond manual manipulation for treating subluxation of the spine); and
- o Medicare payment amounts which may be inappropriate in a system based on relative resource consumption -- since the physician work component assumes physician performance and clinical work of "incident to" staff is reflected and valued through the practice expense component established by Congress under the Medicare physician fee schedule.

This proposal would result in Medicare paying the appropriate rate when covered non-physician practitioners are performing services. There would be no Medicare payment when staff without practitioner status are performing services. Finally, this proposal would result in an accurate delineation of what constitutes physician work versus clinical work of "incident to" staff -- helping to promote more accurate physician fee schedule payments. Physicians would continue to be able to use incident to staff in an "assisting" capacity and those staff activities would be appropriately reflected in the practice expense component of the physician fee schedule payment.

**Effect on Beneficiaries:** Requiring that Medicare pay only when a covered practitioner performs the physician/practitioner "work" in a service and then only at the appropriate practitioner rate would reduce the likelihood of beneficiaries being treated by unlicensed or untrained staff. Also, when Medicare pays at the correct rate, beneficiaries would be paying their 20% coinsurance of an amount that is appropriate for the service actually received. They would not be paying 20% of a physician allowance, when a physician did not actually perform the work.

**Cost:** Some small savings are likely.

HEALTH CARE FINANCING ADMINISTRATION  
FISCAL YEAR 1999 LEGISLATIVE PROPOSAL

Civil Monetary Penalties for False Certification

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

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

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

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

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

**Cost:** To be determined.

HEALTH CARE FINANCING ADMINISTRATION  
FISCAL YEAR 1999 LEGISLATIVE PROPOSAL

Civil Money Penalties

Improve the Agency's Ability to Effectively Implement Section 1842(j)(2) of the Act.

**Current Law:** Section 1842(j)(2) provides for civil money penalties to be assessed for a number of areas involving non-compliance with Medicare's rules and regulations. These penalties are to be enforced in the same manner as penalties under section 1128A. However, the effect of this cross reference eliminates the monetary penalty because section 1842(j)(2) does not itself authorize a specific penalty amount, but does reference exclusion of the first two sentences of section 1128A, which does provide a specific penalty amount.

**Proposal:** Correct the apparent statutory oversight which did not specify a dollar amount for civil money penalties that may be imposed upon: non-participating physicians who bill more than the limiting charge; providers who bill for clinical diagnostic laboratory tests other than on an assignment-related basis; physicians who bill on an unassigned basis for services rendered to dually eligible beneficiaries; non-participating 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; non-participating radiologists who bill more than the limiting charge; nonparticipating physicians who bill more than the limiting charge for mammographies; physicians who bill for assistants at cataract surgery; non-participating physicians who do not make refunds to beneficiaries for medically unnecessary and/or poor quality of care services; and physicians who repeatedly bill beneficiaries for certain diagnostic tests in excess of the limiting charge.

**Rationale:** This proposal is necessary to eliminate a conflict in the current statutory language and ensures that the penalty is enforceable and collectible by law. A literal reading of the current statutory language would appear to produce contradictory results because the dollar amount for the civil money penalty would be removed, as would the authority to impose an assessment.

**Effect on Beneficiaries:** Beneficiaries would indirectly benefit since this technical change would permit HCFA to enforce the statute without the likely potential of litigation over the ambiguity caused by the current language.

**Cost:** Costly litigation may be avoided.

**Effective Date:** Upon enactment.

HEALTH CARE FINANCING ADMINISTRATION  
FISCAL YEAR 1999 LEGISLATIVE PROPOSAL

Medicare Secondary Payer

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

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

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

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

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

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

**Cost:** To be determined. Medicare does not know the extent to which there are insurance

payments that are primary to Medicare about which Medicare is never notified.

HEALTH CARE FINANCING ADMINISTRATION  
FISCAL YEAR 1999 LEGISLATIVE PROPOSAL

Data Match Responses

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

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

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

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

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

Cost: To be determined.

Effective Date: Upon enactment.

HEALTH CARE FINANCING ADMINISTRATION  
FISCAL YEAR 1999 LEGISLATIVE PROPOSAL

Set Conditions for Double Damages

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

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

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

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

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

Cost: To be determined.

Effective Date: Upon enactment.

HEALTH CARE FINANCING ADMINISTRATION  
FISCAL YEAR 1999 LEGISLATIVE PROPOSAL

Clarify Time and Filing Limitations

Clarify circumstances in which Medicare may recover mistaken payments.

Current Law: Under current statutory authority, Medicare is permitted to recover Medicare Secondary Payer mistaken primary payments from group health plans within 3 years after the date of services without regard to a plan's timely filing requirements.

Proposal: Clarify that Medicare can recover mistaken primary payments from group health plans without regard to a group health plan's timely filing period or the general statute of limitations on collection of all other debts to Federal government.

Rationale: If Medicare is not aware that a beneficiary has group health plan coverage and Medicare is billed for the primary payment, it mistakenly pays primary. When Medicare discovers that the beneficiary had group health plan coverage that was primary to Medicare, Medicare attempts to recover the amount of the mistaken primary payment from the group health plan. The discovery process is time consuming because Medicare generally must utilize information from tax returns, matched against information from the Social Security Administration (in the HCFA/IRS/SSA Data Match). Medicare then sends a questionnaire to identified employers to determine if a Medicare beneficiary (or his/her spouse) had coverage through the group health plan of an employer. The answers must be matched against HCFA records. This process takes more than 3 years from the end of a calendar tax year. Thus, a three-year limit on Medicare recovering mistaken payments effectively means that no mistaken primary payments would be received. Consequently, group health plans (whose obligation is to pay before Medicare when the beneficiary has a primary policy) receive substantial windfalls at the expense of the Medicare program.

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

Cost: This proposal was scored at \$187 million in savings over 5 years when the Administration's fraud bill was submitted to the Congress.

Effective Date: Upon enactment.

HEALTH CARE FINANCING ADMINISTRATION  
FISCAL YEAR 1999 LEGISLATIVE PROPOSAL

Extension of Subpoena and Injunction Authority

Extend the Subpoena and Injunction Authority.

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

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

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

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

Cost: To be determined.

HEALTH CARE FINANCING ADMINISTRATION  
FISCAL YEAR 1999 LEGISLATIVE PROPOSAL

Kickback Penalties for Knowing Violations

Amend the Social Security Act Regarding Kickback Penalties for Knowing Violations.

**Current Law:** Section 1128B(b) established penalties for anyone who knowingly and willfully solicits or receives any remuneration directly or indirectly, overtly or covertly, in cash or in kind, for referral of medical services.

**Proposal:** Remove "and willfully" from Section 1128b to return to the normal burden of proof.

**Rationale:** This proposal would establish that the government has the same burden of proof under the anti-kickback laws as with other criminal statutes. 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.

**Effect on Beneficiaries:** Medicare beneficiaries would benefit from a more efficiently run program.

**Cost:** Before enactment of the Balanced Budget Act of 1997, this proposal, along with six other provider sanction provisions, was estimated at \$0 over 5 years.

**Effective Date:** Upon enactment.

HEALTH CARE FINANCING ADMINISTRATION  
FISCAL YEAR 1999 LEGISLATIVE PROPOSAL

Expansion of Criminal Penalties for Kickbacks

Expand Criminal Penalties for Kickbacks.

Current Law: Section 1128B(b) applies criminal penalties for kickbacks related to Federal health care programs.

Proposal: Create a new, generalized offense against kickbacks paid in connection with any public or private health care benefit program or plan.

Rationale: Those convicted under this proposed new generalized authority would be subject to up to five years imprisonment as well as to fines. This proposal would fill a gap in current law by extending Federal anti-kickback criminal sanctions to all public and private health care programs and plans.

Effect on Beneficiaries: All health insurance beneficiaries would benefit from stopping fraudulent behavior in the health insurance system.

Cost: Prior to enactment of the Balanced Budget Act of 1997, this proposal, along with six other provider sanction proposals was scored at \$0 over 5 years.

Effective Date: Upon enactment.

HEALTH CARE FINANCING ADMINISTRATION  
FISCAL YEAR 1999 LEGISLATIVE PROPOSAL

Recovery in Bankruptcy Situations

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

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

**Proposal:** Provide that:

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

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

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

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

Cost: To be determined.

HEALTH CARE FINANCING ADMINISTRATION  
FISCAL YEAR 1999 LEGISLATIVE PROPOSAL

Civil Monetary Penalties for Services Ordered or Prescribed by Excluded Providers

Impose Civil Money Penalties (CMPs) for Services Ordered or Prescribed by an Excluded Individual or Entity.

Current Law: Under Section 1128A, the Secretary can authorize CMPs against any provider who provides a medical item or service during a time when that person is excluded from the program under which the claim is made.

Proposal: Authorize the Secretary to impose civil money penalties against anyone who knows or should have known that they are submitting claims for services ordered or prescribed by an individual who is excluded from participating in Medicare or State health programs.

Rationale: This proposal helps close a loophole in current law. The current law allows CMPs to be levied only against excluded individuals who are directly furnishing a service. This proposal allows CMPs to be imposed against individuals providing services ordered by an excluded provider even after that individual and entity have been notified that the provider has been excluded.

Effect on Beneficiaries: This provision would ensure that only approved individuals are providing Medicare services, while also tightening up the exclusion rules to keep fraudulent individuals from continuing to bill Medicare.

Cost: To be determined.

HEALTH CARE FINANCING ADMINISTRATION  
FISCAL YEAR 1999 LEGISLATIVE PROPOSAL

Reinstate Reasonable Diligence for CMPs

Reinstate the Reasonable Diligence Standard Concerning Levels of Knowledge Required for Imposition of Civil Monetary Penalties (CMPs).

Current Law: Under Section 1128A of the Social Security Act, civil monetary penalties can be imposed for false and fraudulent claims that are submitted for reimbursement under the Medicare and Medicaid programs. Section 231(d) of HIPAA altered the legal burden of proof for the government and made providers subject to civil monetary penalties only if they acted with "deliberate ignorance" or "reckless disregard" of the truth.

Proposal: Repeal Section 231(d) of HIPAA in order to return to the previous standard of reasonable diligence for imposing CMPs against providers who submit fraudulent Medicare and Medicaid claims.

Rationale: The Office of the Inspector General (OIG), which has the authority to impose these CMPs for the Secretary, often deals with cases of negligent billing practices. In some of these cases, the providers in question claim ignorance of any potential violations of law and defer all claims decisions to billing clerks. By taking part in the Medicare program, providers assume an inherent responsibility for knowing the Medicare coverage and billing rules directly or ensuring that their billing staff is properly trained in submitting claims. Until recently, the OIG relied on a legal standard of reasonable diligence in order to impose CMPs against fraudulent health care providers. HIPAA altered the requirements for imposition of CMPs in these cases and created a legal standard that put the OIG at a disadvantage. Under this standard, the OIG would have to prove that a provider acted in deliberate ignorance of the law in order to impose a CMP. This proposal would return to the "reasonable person" standard in use before HIPAA. That would allow the OIG to face a fair burden of proof in pursuing CMPs against providers who continue to be involved in negligent billing practices despite notifications and warnings.

Effect on Beneficiaries: This proposal would allow the OIG to successfully pursue more claims against fraudulent health care providers and should act as a deterrent against further fraud in the Medicare and Medicaid programs. Pursuing fraud should help ensure increased quality in both programs.

Cost: To be determined.

HEALTH CARE FINANCING ADMINISTRATION  
FISCAL YEAR 1999 LEGISLATIVE PROPOSAL

Rural Health Clinic Coinsurance

Limit coinsurance for rural health clinic services to 20 percent.

**Current Law:** Congress established the Rural Health Clinic (RHC) program in 1977 and provided for reasonable cost reimbursement for RHC services. Beneficiary co-insurance for RHC services may not exceed 20 percent of the reasonable charge for the service.

**Proposal:** Limit beneficiary coinsurance for RHCs services to 20 percent of the Medicare per-visit payment limit. Eliminate coinsurance for pneumococcal and influenza vaccines and their administration.

**Rationale:** When the RHC program was first implemented, HCFA established rules requiring that beneficiary coinsurance responsibility be assessed based on the RHC's charge for the service. At that time, RHC charges were more closely related to costs. This is no longer the case, and RHCs are collecting beneficiary coinsurance amounts based on charges which sometimes significantly exceed the Medicare RHC cost per visit. This proposal would lower beneficiary coinsurance payments to 20 percent of the Medicare cost per visit.

**Effect on Beneficiaries:** Beneficiaries currently pay an effective coinsurance rate greater than 20 percent for RHC services. Under this proposal, coinsurance would be reduced to the 20 percent level.

**Cost:** Negligible.

HEALTH CARE FINANCING ADMINISTRATION  
FISCAL YEAR 1999 LEGISLATIVE PROPOSAL

Medicare Medical Review

Eliminate the Legislatively-Mandated Utilization Screen for Physician Services Provided to Patients in Rehabilitation Hospitals.

Current Law: Section 4085(h) of OBRA-87 required the Secretary to establish a separate utilization screen for physician visits to patients in rehabilitation hospitals and rehabilitation units, as well as patients in long-term care hospitals receiving rehabilitation services, to be used by Medicare carriers.

Proposal: Eliminate the requirements for the operation of this screen.

Rationale: HCFA requires all carriers to employ specific pre-payment medical review edits or "screens" for services subject to abuse or with potential to be subject to abuse to ensure that Medicare pays only for covered services.

In the 1980s, HCFA identified certain "mandated screens" that each carrier was required to operate. Since that time, HCFA has determined that it is more effective to require carriers to perform analysis of claims data to determine which services are most problematic and then focus their review efforts on those services. As of October, 1997, HCFA has eliminated all of the "mandated screens" for carriers with one exception: the statutorily mandated screen for rehabilitation physicians.

This congressionally-mandated review screen imposes requirements to correct a specific problem which, in fact, may not be a problem nationally. Such medical review adds unnecessary costs to the Medicare program. Eliminating the mandated screen for rehabilitation services would allow those carriers that have aberrant rehabilitation providers in their jurisdiction to operate a local screen for rehabilitation services, while at the same time allowing those carriers that do not have a problem in their area to focus their resources on more significant problems.

Effect on Beneficiaries: None.

Cost: Negligible. Carrier data show that the screen has had little impact on the number of claims denied versus the number paid.

Effective Date: Upon enactment.

### **Competitive Bidding Proposal \***

This proposal authorizes the Secretary to set payment rates for SMI items and services (excluding physician services) specified by the Secretary based on competitive bidding. The items and services included in a bidding process and the geographic areas selected for bidding will be determined by the Secretary, based on the availability of entities able to furnish the item or service and the potential for achieving savings. Bids will be accepted from entities only if they meet quality standards specified by the Secretary.

\* Note: This proposal may not have been sent to OMB yet.