
Clinton Presidential Records Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a publication.

Publications have not been scanned in their entirety for the purpose of digitization. To see the full publication please search online or visit the Clinton Presidential Library's Research Room.



Department of Justice Health Care Fraud Report

Fiscal Years 1995-1996

*The Health Insurance Portability and Accountability Act
of 1996 ("HIPAA" aka "Kassebaum-Kennedy"),
P.L.104-191, signed August 21, 1996*

18 U.S.C. § 1347, Health care fraud statute; Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice- (1) to defraud any health care benefit program; or (2), to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program, in connection with the delivery of or payment for health care benefits, items, or services (shall be guilty of an offense.)

18 U.S.C. § 1956(c)(7)(F), the Money Laundering statute was amended to include "Federal health care offense" as a specified unlawful activity.

The United States may recover treble damages and a civil penalty of \$5,000 to \$10,000 per violation.

**18 U.S.C. § 371,
Conspiracy to
Defraud the United
States**

Program Fraud Civil Remedies Act, 31 U.S.C. §§ 3801-3812

18 U.S.C. § 669, Theft or Embezzlement in connection with health care

Civil False Claims Act, 31 U.S.C. §§ 3729-3733

Qui Tam provisions of the False Claims Act

18 U.S.C. § 1035, False Statements relating to Health Care Matters

42 U.S.C § 1320a-7b, Criminal Penalties for Acts Involving Medicare or State Health Care Programs

42 U.S.C. § 1320a-7a, Civil Money Penalties for specified fraud and abuse violations are extended from Medicare and Medicare programs to all other federal health care programs

18 U.S.C. § 3486, Authorized Investigative demand procedure for DOJ Investigations relating to Federal criminal health care fraud offenses.



U.S. Department of Justice

Office of the Deputy Attorney General

Washington, D.C. 20530

FAX TRANSMISSION SHEET

TO: Chris Jennings

DPC

Phone: _____ Fax: 456-5557

FROM: John T. Bentivoglio
Special Counsel for Health Care Fraud

Phone: (202) 514-2707 Fax: (202) 514-6897

DATE: 1/18/98

NUMBER OF PAGES (including this cover sheet): 6

MESSAGE: _____

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

DRAFT

FOREWORD

To the Senate and the House of Representatives
of the United States of America in Congress Assembled:

Fraud in the U.S. health care system is a serious problem that impacts every person in this country. The U.S. General Accounting Office estimated that more than \$100 billion -- about 10 percent of the \$1 trillion spent on health care each year in this country -- is lost to fraud and abuse each year. On July 16, 1997 the Inspector General of the Department of Health and Human Services issued a report that concluded that the Medicare program alone has overpaid hospitals, doctors, and other health care providers in 1996 by an estimated \$23 billion. These improper payments could range from inadvertent mistakes to outright fraud and abuse. We can not quantify what portion of the improper payments are attributable to fraud.

Dollars alone, however, do not adequately measure the impact of health care fraud on our nation. Fraud and abuse in the health care industry pose a direct -- and potentially growing -- threat to the lives and health of millions of Americans. For example, investigators and prosecutors have uncovered numerous schemes where health care cheats charge for life-saving medical tests that are not performed. Decisions which physicians make each and every day -- whether and where to hospitalize a patient, what lab tests to order, what surgical procedures to perform, what drugs to prescribe, and how long to keep a patient in a facility -- affect the health and well-being of all Americans. We cannot allow the creation of financial inducements to corrupt the judgement of professional medical providers, providers whom the American people have been taught to trust for years.

The Department of Health and Human Services and the Department of Justice, along with other federal, state and local agencies, are committed to the aggressive enforcement and prevention of health care fraud in this country. The creation of the Health Care Fraud and Abuse Control Program has greatly enhanced the abilities of the law enforcement community to prevent, detect, investigate, and prosecute health care fraud matters.

The success of the program comes from the hard work done on a day-to-day basis by dedicated investigators, auditors, prosecutors, and support personnel across this nation. This inaugural Annual Report highlights their outstanding contributions.

Respectfully submitted,

Donna Shalala
Secretary

Janet Reno
Attorney General

DRAFT

EXECUTIVE SUMMARY

Fraud and abuse in the U.S. health care system costs Americans an estimated \$100 billion each year. Perhaps even more disturbing, 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 the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). HIPAA provided powerful new criminal and civil enforcement tools and \$104 million in resources dedicated to the fight against health care fraud. (Separately, the Federal Bureau of Investigation received \$47 million which is discussed in Appendix One.) In addition, HIPAA required the Attorney General and the Inspector General of the Department of Health and Human Services 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 over \$1.2 billion in judgments and settlements in health care fraud cases. Aggressive efforts by federal law enforcement authorities also resulted in the collection of \$1.087 billion in criminal fines, civil judgments and settlements, and administrative sanctions in health care fraud and abuse cases. There is no direct correlation between new judgments and settlements and actual collections, as the collections include the culmination of some 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.

DRAFT

A significant portion of the \$1.087 collected were 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.

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.



**U.S. Department of Health & Human Services
Health Care Financing Administration
Office of Legislation**

Fax Sheet

To: Chris Jennings

From: Debbie Chang
202-690-5960

Fax:

Number of Sheets including Cover: 2

Comments:

HCFA 1999 Medicare Budget Proposals (Approved by OMB)				
Topic	Current Law	Proposal	Savings	
			FY 99 & X 5 yrs (in millions \$)	
Partial Hosp.	Partial hospitalization services are furnished by a hospital to its outpatients or by a community mental health center. There is currently no restriction on where partial hospitalization services may be furnished.	Preclude providers from furnishing partial hospitalization services in a beneficiary's home or in an inpatient or residential setting.	-15	-120
Medicare Drug Payments	Before Jan. 1, 1998, Medicare paid for drugs based on the Average wholesale price" (AWP). The AWP is a "sticker" price set by drug manufacturers. Beginning January 1, 1998 with the implementation of Section 4556 of the Balance Budget Act, Medicare's payment for drugs and biologicals is 95% of the AWP.	Eliminate the mark-up for drugs by basing Medicare's payment on the provider's acquisition cost of the drug.	-70	-120
Epoetin	Reimbursement for EPO is \$10 per 1,000 units administered.	Reduce the rate HCFA reimburses for EPO to \$9 per 1,000 units administered.	-45	-320
Medicare As Secondary Payer	There is no statutory requirement for group health plans to report to Medicare the identities of those beneficiaries for whom they are responsible for primary coverage.	Require all insurance companies to match their commercial enrollment records with Medicare.	-10	-690
User Fees	Providers are not charged for any claims submitted. Claims process is funded by HCFA administrative funds.	Charge \$1 for duplicate or unprocessable claims	+35.5	NA
	The higher costs of processing paper claims are paid for through HCFA's funding to its contractors.	Charge for processing paper claims	+ 55	NA
	Provider enrollment costs are paid for by HCFA's program management appropriation.	Charge provider enrollment registration fee	+ 20	NA
	HCFA administrative funds cover the processing of applications and renewals from health plans.	Charge health plans for processing initial applications and renewed contracts	+ 36.7	NA
	Congress appropriates funds to pay for survey and certification. HCFA is prohibited by Section 1864 of the SSA from charging providers and suppliers for costs incurred in survey and certification.	Charge fee to cover 100% of initial certification costs	+ 10	NA
	Congress appropriates funds to pay for survey and certification. HCFA is prohibited by Section 1864 of the SSA from charging providers and suppliers for costs incurred in survey and certification.	Charge fee to cover 33% of recertification costs	+ 52.3	NA
	These costs are covered solely by Medicare Integrity Program fees.	Charge fee to cover all audit and cost settlement activity	+ 395	NA

**President Clinton Announces Home Health Moratorium Is Being Lifted Because New
Tough Anti-Fraud Regulations Are In Place
January 13, 1998**

Medicare is more than just another program. For millions of Americans it is a lifeline. Maintaining the integrity of that lifeline has long been a top priority of this Administration.

Last September, I announced that the Department of Health and Human Services was declaring the first ever moratorium to stop new home health providers from entering the Medicare program. We took this unprecedented action to give the Administration the opportunity to implement new regulations to create protections to screen out providers who are likely to cheat Medicare.

Today I am announcing that the Department is removing the moratorium because the new tougher regulations are in place to root out fraud and abuse in the home health industry. These regulations will help keep bad apple providers out of the home health industry. These actions -- combined with other anti-fraud initiatives and other savings initiatives -- have helped slow the growth of home health spending. In fact, the Medicare actuary now reports that the rate of increased Medicare spending on home health is [down to] just 5.4 percent -- down from previous rates that exceeded 25 percent.

These efforts to root fraud and abuse out of the home health industry build on my Administration's longstanding efforts to combat fraud and abuse. Since 1993, we have assigned more federal prosecutors and FBI agents to fight health care fraud than ever before. As a result, convictions have gone up a full 240 percent and we have saved some \$20 billion in health care claims. The Kassebaum-Kennedy legislation I signed into law created -- for the first time ever -- a stable funding source to fight fraud and abuse. This year's historic Balanced Budget Act, which ensured the life of the Medicare Trust Fund until at least 2010, also gave us an array of new weapons before in our fight to keep scam artists and fly-by-night health care out of Medicare and Medicaid.

I would like to thank the Department of Health and Human Services and the Department of Justice for their efforts to help combat fraud and abuse in the home health industry.

We will continue to work to assure that we do everything possible to combat fraud and abuse in our Medicare and Medicaid programs.



Fraud & Abuse 54

PRESIDENT WILLIAM J. CLINTON
RADIO ADDRESS ON MEDICARE FRAUD
DECEMBER 13, 1997

Good Morning. I'd like to give you a progress report on our fight against waste, fraud and abuse in our Medicare system. Medicare is more than just a program; it reflects our values. It is one way we honor our parents and grandparents -- and protect our families. This summer, we took historic action to strengthen Medicare by improving benefits, expanding choices for recipients, and extending the life of the Trust Fund to at least the year 2010. I have also named four distinguished experts to a bipartisan commission that will find ways to ensure Medicare will serve baby boomers and our children as well as it has served our parents.

But to protect Medicare and the fundamental values it represents, we must also vigorously fight waste, fraud and abuse in the system. These activities diminish our ability to provide high-quality, affordable care for some of our most vulnerable citizens. Medicare fraud costs billions of dollars every year, amounting to an unfair fraud tax on all Americans. Our taxpayers deserve to expect that every cent of their hard-earned money is spent on quality medical care for deserving patients.

I am proud of what we've already accomplished to crack down on waste, fraud and abuse in Medicare. Since 1993, we have assigned more federal prosecutors and FBI agents to fight health care fraud than ever before. As a result, convictions have gone up 240 percent. We have saved \$20 billion in health care claims. Two years ago, the Department of Health and Human Services launched Operation Restore Trust, which has already identified \$23 in fines and settlements for every dollar invested. Our historic balanced budget gives us an array of new weapons to keep scam artists and fly-by-night health care providers out of Medicare. And earlier this fall, I announced new actions to root out fraud and abuse in the mushrooming home health industry -- from a moratorium on new home health agencies in the system to a doubling of audits to a new certification renewal process.

But we must do more. Sometimes the waste and abuses aren't even illegal, but embedded in the system. Last week, the Department of Health and Human Services confirmed that our Medicare program has been systematically overpaying doctors and clinics for prescription drugs -- overpayments that cost taxpayers hundreds of millions of dollars. Such waste is simply unacceptable. These overpayments occur because Medicare reimburses doctors according to the published average wholesale price -- "the sticker price" -- for drugs. Few doctors, however, actually pay full sticker price. In fact, some pay just one tenth of the published price. That is why I am sending to Congress the same legislation I sent last year -- legislation that will ensure doctors are reimbursed no more and no less than the price they themselves pay for the medicines they give Medicare patients. While a more modest version of this bill passed last summer, the savings to taxpayers is not nearly enough. My bill will save \$700 million over the next five years. I urge Congress to pass it.

There is no room for waste, fraud and abuse in Medicare. Only by putting a permanent stop to it can we honor our parents, protect our taxpayers and build a world-class health care system for the 21st century.

PRESIDENT CLINTON ANNOUNCES EFFORTS TO BUILD ON HIS STRONG RECORD OF FIGHTING FRAUD AND WASTE IN THE MEDICARE PROGRAM

December 13, 1997

Today, President Clinton announced that his FY1999 Budget will include a proposal to stop the Medicare program from overpaying for the drugs it covers. This proposal, which will save Medicare and the taxpayers who support it \$700 million over five years, builds on President Clinton's strong record of cutting waste and fighting fraud in the Medicare program.

Proposed Legislation to Stop Medicare from Overpaying for Drugs. A recent report by the HHS Inspector General found that what Medicare currently pays for drugs "bears little or no resemblance to actual wholesale prices that are available to the physicians and supplier community that bill for these drugs." Medicare pays for drugs based on the "average wholesale price (AWP)" -- a "sticker" price set by manufacturers and published in several commercial catalogs, rather than the average price actually charged by wholesalers to their customers. The IG report confirmed that Medicare pays hundreds of millions more for 22 of the most common and costly drugs than would be paid if market prices were used. For more than one-third of these drugs, Medicare paid more than double the actual wholesale prices, and in some cases pays as high as ten times the amount.

In his balanced budget proposal last year, the President offered legislation to stop these excessive payments by ensuring that Medicare does not overpay for the drugs it covers. Congress passed a modest version of this bill in the balanced budget agreement, by reducing payments to 95 percent of the AWP. However, this reduction does not go far enough. The President is proposing that the Medicare payments be reduced to the actual amount that the drugs cost. This legislation will save \$700 million over five years and builds on the President's strong record of fighting fraud and cutting waste in Medicare. Since he took office, the President has:

Added Three New Weapons to the Anti-fraud Arsenal to Combat Fraud and Abuse in the Home Health Industry. The President recently announced a set of initiatives to eliminate fraud and abuse in the home health care industry: (1) an immediate moratorium on all new home health providers coming into the Medicare program; (2) a new renewal process for home health agencies currently in the program; and (3) a doubling of audits that will help weed out bad apple providers. Home health care is the most rapidly expanding part of Medicare, with nearly 100 new home health providers entering Medicare each month. These actions are consistent with recommendations by the Inspector General at the Department of Health and Human Services following a recent report on fraud in the home health care industry.

Took Strong Action to Fight Fraud and Abuse Right When He Took Office. The President's first budget closed loopholes in Medicare and Medicaid to crack down on fraud and abuse. In 1993, the Attorney General put fighting fraud and abuse at the top of the Justice Department's agenda. Through increased resources, focused investigative strategies and better coordination among law enforcement, the Justice Department increased the number of health care fraud convictions by 240 percent between FY1993 and FY1996 and we have saved taxpayers more than \$20 billion.

Launched Operation Restore Trust -- a Comprehensive Initiative to Fight Fraud and Abuse in Medicare and Medicaid. Two years ago the Department of Health and Human Services launched Operation Restore Trust, a comprehensive anti-fraud initiative in five key states. Since its inception, Operation Restore Trust has identified \$23 for every one dollar invested in fines, recoveries, settlements, audit disallowances, and civil monetary penalties owed to the Federal Government.

Obtained Additional Resources to Fight Fraud and Abuse When the President Signed Into Law Kassebaum-Kennedy Legislation. In 1996, the President signed the Health Insurance Portability and Protection Act (Kassebaum-Kennedy) into law which, for the first time, created a stable source of funding for fraud control. This legislation is enabling HHS to expand Operation Restore Trust to twelve states.

Passed New Initiatives to Combat Fraud and Waste Proposed by the President in the Balanced Budget Act of 1997. The Balanced Budget Act the President signed into law in August also included important new protections to fight fraud and abuse in Medicare and Medicaid. These new initiatives included:

- requiring providers to give proper identification before enrolling in Medicare;
- implementing new penalties for services offered by providers who have been excluded by Medicare or Medicaid;
- establishing guidelines for the frequency and duration of home health services;
- clarifying the definition of part-time or intermittent nursing care which will clarify the scope of the Medicare benefit and will make it easier to identify inappropriate services;
- establishing a prospective payment system (PPS) for home health services to be implemented in FY 1999, enabling HCFA to stem the excessive flow of home health care dollars;
- clearly defining skilled services so that home health agencies can no longer pad their bills with unnecessary services when a patient simply needs a simple service such as their blood drawn;
- and eliminating periodic interim payments that were made in advance to agencies and not justified until the end of the year.

PRESIDENT CLINTON ADDS THREE NEW WEAPONS TO BUILD ON STRONG RECORD OF FIGHTING FRAUD AND ABUSE

Today President Clinton added three new weapons to the anti-fraud arsenal to combat fraud and abuse in the home health industry. The President announced: (1) an immediate moratorium on all new home health providers coming into the Medicare program to allow the Health Care Financing Administration to implement new regulations to prevent fly-by-night providers from entering Medicare; (2) a new renewal process for home health agencies currently in the program to ensure that all Medicare providers have to abide by these tough new regulations; and (3) a doubling of audits that will help weed out bad apple providers. These actions are consistent with recommendations to reduce fraud in home health by the Inspector General at the Department of Health and Human Services following a recent report on fraud in the home health care industry. These new initiatives build on the President's unprecedented record of fighting fraud and abuse in Medicare and Medicaid.

Took Strong Action to Fight Fraud and Abuse Right When He Took Office. The President's first budget closed loopholes in Medicare and Medicaid to crack down on fraud and abuse. In 1993, the Attorney General put fighting fraud and abuse at the top of the Justice Department's agenda. Through increased resources, focused investigative strategies and better coordination among law enforcement, the Justice Department increased the number of health care fraud convictions by 240 percent between FY1993 and FY1996 and we have saved taxpayers more than \$20 billion.

Launched Operation Restore Trust -- a Comprehensive Initiative to Fight Fraud and Abuse in Medicare and Medicaid. Two years ago the Department of Health and Human Services launched Operation Restore Trust, a comprehensive anti-fraud initiative in five key states. Since its inception, Operation Restore Trust has identified \$23 for every one dollar invested; identified more than \$187.5 million in fines, recoveries, settlements, audit disallowances, and civil monetary penalties owed to the Federal Government.

Obtained Additional Resources to Fight Fraud and Abuse When the President Signed Into Law Kassebaum-Kennedy Legislation. In 1996, the President signed the Health Insurance Portability and Protection Act (Kassebaum-Kennedy) into law which, for the first time, created a stable source of funding for fraud control. This legislation is enabling HHS to expand Operation Restore Trust to twelve states.

Passed New Initiatives to Combat Fraud and Waste Proposed by the President in the Balanced Budget Act of 1997. The Balanced Budget Act the President signed into law in August also included important new protections to fight fraud and abuse in Medicare and Medicaid. These new initiatives included:

- requiring providers to give proper identification before enrolling in Medicare;
- implementing new penalties for services offered by providers who have been excluded by Medicare or Medicaid;
- establishing guidelines for the frequency and duration of home health services;
- clarifying the definition of part-time or intermittent nursing care which will clarify the scope of the Medicare benefit and will make it easier to identify inappropriate services;
- establishing a prospective payment system (PPS) for home health services to be implemented in FY 1999, enabling HCFA to stem the excessive flow of home health care dollars;
- clearly defining skilled services so that home health agencies can no longer pad their bills with unnecessary services when a patient simply needs a simple service such as their blood drawn;
- and eliminating periodic interim payments that were made in advance to agencies and not justified until the end of the year.

BILL THOMAS, CALIFORNIA, CHAIRMAN
SUBCOMMITTEE ON HEALTH

BILL ARCHER, TEXAS, CHAIRMAN
COMMITTEE ON WAYS AND MEANS

NANCY L. JOHNSON, CONNECTICUT
JIM MCCREY, LOUISIANA
JOHN ENSIGN, NEVADA
JON CHRISTENSEN, NEBRASKA
PHILIP M. CRANE, ILLINOIS
AMO HOUGHTON, NEW YORK
SAM JOHNSON, TEXAS

A. L. SINGLETON, CHIEF OF STAFF
CHARLES N. KAHN, JR. SUBCOMMITTEE STAFF DIRECTOR

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

JANICE MAYE, MINORITY CHIEF COUNSEL
BILL VALUGHAN, SUBCOMMITTEE MINORITY

SUBCOMMITTEE ON HEALTH

FORTNEY PETE STARK, CALIFORNIA
BENJAMIN L. CARDIN, MARYLAND
GERALD D. KLECKA, WISCONSIN
JOHN LEWIS, GEORGIA
XAVIER BECERRA, CALIFORNIA

Ex Office:
BILL ARCHER, TEXAS
CHARLES B. RANGEL, NEW YORK

Medicaid Provider Hospitalization R/A

TO CHRIS JENNINGS

ALSO BRYANT HALL IN

GRAHAM'S OFFICE IS WORTH

TALKING TO ON THIS

Bin

E1978

CONGRESSIONAL RECORD — Extensions of Remarks

October 8, 1997

wife of Granada, CO; John Brown and wife Patricia of Campo, CO; sister-in-law Cheryl and husband Paul George of Amarillo, TX; plus many nieces and nephews, and a host of friends and relatives.

Mr. Speaker, I would also like to share some thoughts his wife Paulette shared with me. "I can truthfully say my husband was honorable. His heart dictated what was true and honest. In my eyes, many times, he always took the hard road. The easy way out was never the right way. For every situation God had already set the standard."

Mr. Speaker, Norman Wayne Wright is a symbol of what America stands for, family values, hard work and a solid faith in the Lord. Thank you for giving me this opportunity to share his memory with the House today.

PERSONAL EXPLANATION

HON. ROBERT A. WEYGAND

OF RHODE ISLAND

IN THE HOUSE OF REPRESENTATIVES

Wednesday, October 8, 1997

Mr. WEYGAND. Mr. Speaker, I was unfortunately detained in my district Monday, October 6, 1997 and a portion of Tuesday, October 7, 1997 and missed several votes as a result.

Had I been here, I would have voted in the following way: I would have voted "yea" on rollcall votes 490, 491, 492, 493 and 496; I would have voted "nay" on rollcall votes 494 and 495.

As exporting becomes increasingly more important to U.S. businesses, the role of the Export-Import Bank must be maintained. The Export-Import Bank places businesses in my district and districts across the nation on a level playing field when competing against foreign businesses subsidized by foreign governments. This program allows for the expansion of U.S. markets thereby increasing the stability of our economy and preserving American jobs. I would, therefore, have voted in favor of reauthorizing the Export-Import Bank.

I would also have voted for the conference report on the Department of Agriculture Appropriations bill for Fiscal Year 1998. Among many important programs, this conference report includes full funding for the Food and Drug Administration's initiative to curb underage smoking in our country. In addition, the bill provides over \$3.9 billion—\$118 million more than approved by the House of Representatives—for the important Women, Infants and Children's (WIC) nutritional program.

I would also have voted in favor of instructing the House conferees to Foreign Operations Appropriations Conference Committee to insist on the House approved provisions to reinstate the "Mexico City" policy. It is my belief that federal funds should not be used to fund abortions here or abroad.

MEDICARE PARTIAL HOSPITALIZATION INTEGRITY ACT

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, October 8, 1997

Mr. STARK. Mr. Speaker, on behalf of Representative KAREN THURMAN and myself, I am

today introducing legislation to reform Medicare's partial hospitalization benefit.

The partial hospitalization benefit is an important addition to Medicare, helping people with substantial mental health needs, who in the absence of this service would need to be hospitalized.

Unfortunately, Congress' effort to provide this improved benefit has become prey to some unethical and corrupt "health care providers." In some areas, the benefit is being badly abused. I include an article from the Miami Herald of September 2, 1997, which describes the situation in Florida.

The bill we are introducing today will deny coverage of services in home and nursing home settings; establish quality standards that will prevent fly-by-night operators from being eligible to participate; establish a prospective payment system for the partial hospitalization benefit, so that costs are brought under control; and provide a demonstration project to determine whether more comprehensive services by quality providers can indeed save Medicare some revenues.

The administration proposed most of these changes this summer, but the partial hospitalization problem was new to Congress and we did not have time to consider these proposals in this summer's Balanced Budget Medicare Title.

I hope that these provisions can be considered early in the next session of Congress, so that this abuse of the system can be stopped. The situation in Florida indicates that we cannot afford to wait.

The partial hospitalization benefit—when done right—is an important and cost-effective tool to reduce the length of stay of an inpatient hospitalization and to prevent the need for inpatient hospitalization altogether. The reforms we are suggesting have the support of the partial hospitalization, who are as anxious as we are to expel the bad actors from this specialty.

Partial hospitalization is a useful service is well described in the following materials provided by the Association of Behavioral Healthcare, Inc.

[From the Miami Herald, September 2, 1997]

MEDICARE ABUSES SPARK CRY FOR ANTI-FRAUD LAW

(By Peggy Rogers)

Florida's notorious Medicare cheats have yet another type of record—abusing a special psychiatric program out of all proportion to the rest of the nation.

Patient snatching is among the home-grown scams employed in this "partial hospitalization" program, which is supposed to provide several hours a day of intensive psychiatric care. The unwitting elderly and mentally ill, often told they are going on recreational outings, are lured from boarding homes each day to be used as patients.

The boom is astounding. In 1993, Florida outfits billed federal insurers \$2.9 million for partial hospitalization. Last year, Florida's total was \$112 million—half of the \$220 million Medicare spent nationwide for partial hospitalization, federal anti-fraud authorities say.

So "aberrant" and "alarming" are Florida's numbers that state health-care administrators are proposing a state law to clamp down on abusers. If authorities with the Florida Agency for Health Care Administration secure a sponsor, the law requiring licensure of partial hospitalization programs would be considered during the next legislative session.

At the same time, federal authorities in Miami this summer have recommended a moratorium on Medicare billing by new companies.

In 1991, Washington expanded partial hospitalization payments to facilities outside of hospitals. It was intended to save mentally disturbed patients from full hospitalization and save taxpayers money. Services include therapy and stabilization, several hours a day, several days a week.

While Florida consumes half of the program's entire national budget, the state has 26 percent of the private companies providing the service and only 6 percent of the recipients inapplicable Medicare plans, according to a recent report by a Miami-based Medicare anti-fraud squad, Operation Restore Trust.

Eighty percent of the Florida companies are in Dade, Broward and Palm Beach counties.

"We believe that the situation in Florida warrants immediate action," warned Dewey Price, leader of Operation Restore Trust's Miami office.

A moratorium and other recommended actions "should be adopted as quickly as possible to protect both the [Medicare] Trust Fund and the beneficiaries who are supposed to receive partial hospitalization services at these facilities." Price urged policymakers in this report earlier this summer.

Audits in Florida report a "high incidence" of kickbacks to boarding homes for use of their residents, as well as other "widespread, fundamental abuses"—including a lack of medical eligibility by most of the people purportedly receiving treatment.

A temporary ban on admitting new companies to the program would allow Medicare time to regain control of the situation and create lighter policies, authorities say.

One policy now allows partial hospitalization programs to provide care outside their centers. One review found billings for patients from locations as distant as 150 miles.

The companies, typically for-profit outfits, are virtually unregulated.

They are supposed to provide patients with several hours a day of therapy and stabilizing treatment. But spot federal audits found that "none of the group sessions are being led by licensed staff as required by state law to provide psychotherapy" and that "no active treatment is being provided."

The state does not pay for partial hospitalization and has lost little money. But controlling quality is a big concern, along with helping Medicare safeguard public money, said spokeswoman Colleen David of the Agency for Health Care Administration.

"Our fundamental problem is that these programs are not licensed, and licensing is a proxy for monitoring quality," David said. "The program has clearly grown exponentially over a very short period of time."

The number of partial hospitalization centers billing Medicare in Florida grew from none in 1991, the year the federal government expanded the category, to 87 in 1994.

Since then, the number has tripled. Of the 259 Florida companies today, Dade County alone has 161, Broward County has 22 and Palm Beach, 20.

There is also a nationwide problem with increases in spending per patient. Operation Restore Trust's Dewey Price noted, "and nowhere is the situation more alarming than in the state of Florida."

In 1993, three of the state's partial hospitalization programs ranked among the 39 nationwide with the highest per-patient claims. A year later, Florida had 10 of the 30 highest billers. And in 1995, Florida had 22 out of 30.

"Data for 1996 has been requested, and we expect even more aberrant results." Price reported.

[Excerpts from recent publications of the Association for Ambulatory Behavioral Healthcare, Inc.]

The huge and expanding older adult population continues to pose a tremendous challenge to the mental health delivery system, including payers, providers, and purchasers. As the elderly cohort grows, the demands on all levels of services grows exponentially. Depression and other later life psychiatric issues such as anxiety secondary to loss of health or a permanent change in physical condition, difficulty coping with dementia in a spouse, severe grief and loss, and panic over the inability to live independently and the subsequent placement in a nursing home facility are all common events. These problems are generally acute and debilitating and frequently present themselves simultaneously as well as in the context of a limited or nonexistent social support system. At the same time, it has been well documented that the elderly tend to underutilize mental health services because of stigma surrounding psychiatric care, cost and transportation limitations, and both patient and professional bias and misunderstanding that surrounds the detection, need for treatment, and cooperation with follow through for care.

Geriatric partial hospitalization programs are a viable option to improve the mental health services available to the elderly population. First, partial hospitalization addresses the problems of accessibility and acceptability. Generally transportation for patients is provided, and since patients return home each day the stigma associated with an inpatient stay in a psychiatric care facility is averted. Additionally, the treatment takes place in the environment of an age-similar group which has been shown to foster cohesion, therapeutic learning, and consistent application to daily life problems. Second, a geriatric partial hospitalization program is able to respond to diverse patient needs on both the individual and group level, as each patient receives a specifically tailored personalized treatment plan, and the therapy provided in the groups is relevant to a wide variety of patient problems. Treatment specifics are flexible within the standards set forth by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO, 1995) and the Medicare revisions of the guidelines for partial hospitalization (HCFA, 1995). Third, the availability of intensive treatment in partial hospitalization will often avert the need for inpatient care. This fact allows the health care provider to treat the patient at the most appropriate level of care, maintain him or her in the least restrictive environment, and places less stress on the patient, as the partial hospitalization program allows the patient to participate in an intensive psychiatric care program while still maintaining outpatient status. Finally, a geriatric partial hospitalization program is designed to reduce and control psychiatric symptoms, prevent relapse or exacerbation of problems, and improve mental, emotional, and physical functioning, all of which contribute to building in the patient the ability to live as independently as possible while enjoying the highest level of health.

A geriatric partial hospitalization program should be a separate, identifiable, organized unit that provides a significant link within a comprehensive continuum of mental health services, and thus, improves the overall continuity of care for the elderly patient. It is defined as a distinct, organized, time-limited, ambulatory, coordinated, active treat-

ment program that offers structured, therapeutically intensive clinical services, less than 24 hours per day, to elderly patients.

The partial hospitalization program is a complex treatment that is intended for patients who exhibit profound or disabling conditions related to an acute phase of mental illness or an exacerbation of a severe and persistent mental disorder. The program generally operates as an outpatient unit in a hospital or as a part of a community mental health center and is to operate under the direct supervision of a physician. The program is to provide regular, coordinated, diagnostic, medical, psychiatric, psychosocial, occupational therapy, and multi-disciplinary treatment modalities on a more intensive level than is generally provided in an outpatient clinic setting.

Geriatric partial hospitalization programs are designed to serve elderly patients with appropriate clinical diagnoses, diverse medical problems, and a broad band of variability in socioeconomic and educational backgrounds. The geriatric partial hospitalization program must provide active psychiatric treatment and should be clearly distinguishable from an adult day care program, which provides primarily social, custodial, and respite services. An appropriate geriatric partial hospitalization program employs an integrated, comprehensive, and complementary schedule of active treatment approaches that are behaviorally tied to the identified problems and the specific goals contained in the individualized patient treatment plan. Specifically, active treatment refers to the ongoing provision of clinically recognized therapeutic interventions which are goal-directed and based on a written treatment plan. For treatment to be considered active the following criteria must be met:

1. treatment must be directed toward the alleviation of the impairments that precipitated entry into the program, or which necessitate this continued level of intervention.
2. treatment enhances the patient's coping abilities, and
3. treatment is individualized to address the specific clinical needs of the patient.

Geriatric partial hospitalization programs typically serve individuals 65 years of age and older who are experiencing acute psychiatric problems or decompensating clinical conditions which markedly impair their capacity to function adequately on a day-to-day basis. Usually outpatient therapy has not been effective, and without the ongoing structure, support, and active treatment provided by the geriatric partial hospitalization program these patients would require inpatient psychiatric care.

Ambulatory behavioral health services are designed for persons of all ages who present with a psychiatric and/or chemical dependency diagnosis and the need for treatment which is more intensive than outpatient office visits and less restrictive than 24-hour care.

Ambulatory behavioral health services consist of a coordinated array of active treatment components which are determined by an individualized treatment plan based upon a comprehensive evaluation of patient needs.

Ambulatory behavioral health services treat patients requiring intensive therapeutic intervention in a manner which simulates real-life experience and with the least amount of disruption to their normal daily functioning.

Ambulatory behavioral health services are available to patients on a consistent basis and are augmented with 24-hour crisis backup.

Ambulatory behavioral health services require active involvement of the service team

and patient with both community and family resources.

Finally, due to the matching of patient needs with targeted interventions, the provision of treatment in the most appropriate, least restrictive environment, and the reliance on patient strengths, resources and family and community support systems, ambulatory behavioral health services are cost efficient.

[From Medicare Explained, 1996, published by CCH Inc.]

PARTIAL HOSPITALIZATION COVERAGE

Medicare also covers partial hospitalization services connected with the treatment of mental illness. Partial hospitalization services are covered only if the individual otherwise would require inpatient psychiatric care. [Soc. Sec. Act §§1833(c), 1835(a)(2)(F), 1861(a)(2)(B).]

Under this benefit, Medicare covers: (1) individual and group therapy with physicians or psychologists (or other authorized mental health professionals); (2) occupational therapy; (3) services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients; (4) drugs and biologicals furnished for therapeutic purposes that cannot be self-administered; (5) individualized activity therapies that are not primarily recreational or diversionary; (6) family counseling (for treatment of the patient's condition); (7) patient training and education; and (8) diagnostic services. Meals and transportation are excluded specifically from coverage. [Soc. Sec. Act §1861(f)(2).]

The services must be reasonable and necessary for the diagnosis or active treatment of the individual's condition. They also must be reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization. The course of treatment must be prescribed, supervised, and reviewed by a physician. The program must be hospital-based or hospital-affiliated and must be a distinct and organized intensive ambulatory treatment service offering less than 24-hour daily care. [Soc. Sec. Act §1861(f).] Effective October 1, 1991, partial hospitalization services also are covered in community health centers (see §382). [Soc. Sec. Act §1861(f)(3).]

HONORING PETER DANNER

HON. DALE E. KILDEE

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Wednesday, October 8, 1997

Mr. KILDEE. Mr. Speaker, I rise today to honor the recipient of the 1997 Golden Door Award, Mr. Peter Danner. The award will be given posthumously to Mr. Danner at the annual dinner meeting of the International Institute of Flint on Tuesday, October 14. The International Institute of Flint presents this award annually to a foreign-born citizen who has substantially improved life in the Flint community.

Peter Danner was born in Hungary in 1931. His family owned a wholesale grocery business serving southern Hungary. During World War II the business was invaded first by the Germans and then later by the Russians who looted the food for the soldiers. After graduating from high school Peter joined the Hungarian military. He planned to study engineering but the military did not cooperate and he was assigned to work in an office.

In 1956 Peter started his long journey to the United States. Leaving Hungary during the

- Rely on

= 502 / ^{fact} model

- NO

Tom J

(301)
654
9856

File fraud
& Abuse



400 N. Capitol Street, NW • Suite 590 • Washington, DC 20001-1511
Fax 202.393.6499 • Phone 202.393.0860

Facsimile Transmission Cover Sheet

To: Chris Jennings

Destination: _____

Department: _____

Receiver's Fax Number: (____) 456-7028

From: Margaret Nelson

Date: 1/1 Phone: _____ Ext.: _____

Subject: _____

Pages (including cover sheet): 3

Additional notes: FYI



PREMIER

September 29, 1997

President William Jefferson Clinton
The White House
Washington, D. C. 20500

Dear Mr. President:

I am writing to you to applaud your recent efforts to attack fraud and abuse in the Medicare program.

Premier serves over 1800 hospitals and integrated health care delivery systems across the country. Our hospitals and health systems are leaders in providing high quality patient care using the most the innovative approaches to health care delivery, and we do so with a strong emphasis on both integrity and value. We believe that health care providers have a responsibility to their patients as well as to those paying for the care, particularly in the Medicare program given the vulnerability of its beneficiaries and the program's fragile financial situation. This is why we strongly support the moratorium on certification of new home health agencies which you announced on September 15.

As you know, home health care has seen especially rapid growth in recent years, with an increasingly serious problem of fraud. Many patients are dependent on home health services, and most of the home health care provided today is necessary and is delivered by providers with the integrity to not take advantage of beneficiaries or the Medicare program.

But, with the escalating level of fraud, we believe your six-month moratorium on new providers is the right action at the right time. We hope that this will send a strong signal to all providers, not just those providing home health care, that you and the Department of Health and Human Services are serious about combating fraud. The six-month period is long enough to allow the development of appropriate standards for certification as a provider, but is not so long as to raise significant concerns about beneficiaries' access to needed services, especially given the plentiful supply of home health agencies already certified to serve Medicare beneficiaries.

Premier believes that Medicare should establish strong standards for providers desiring to provide health care services to Medicare beneficiaries. For too long, the program has set relatively weak requirements for providers, even when an adequate supply exists to assure access. We do not believe that Medicare has an obligation to certify all who would seek to

Premier, Inc. and related companies

San Diego
12750 High Bluff Drive
Suite 300

Chicago
Three Westbrook Corporate Center
Ninth Floor

Orlando
4501 Chablate Park Drive (SR217)
P.O. Box 668800

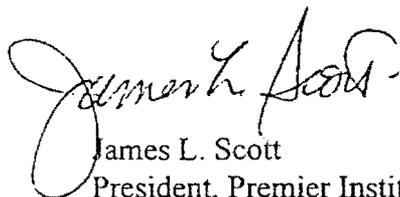
Washington, DC
400 N. Capitol Street, NW
Suite 500

Letter to President William Jefferson Clinton
September 29, 1997
Page Two.

provide services. Instead, standards should be high enough to guarantee Medicare beneficiaries the highest quality care available, consistent with cost and access.

Again, we applaud you for taking the tough action of imposing a moratorium. We hope that this will lead to a new emphasis on high standards of quality, cost and integrity for those who would seek to provide health care services to Medicare beneficiaries.

Sincerely,

A handwritten signature in cursive script that reads "James L. Scott". The signature is written in dark ink and is positioned above the printed name and title.

James L. Scott
President, Premier Institute

PRESIDENT CLINTON LAUNCHES NEW ATTACK ON HOME CARE FRAUD

10
Oct 9-15-97
page 20

President Clinton today announced a three-part initiative to sharpen the administration's attack on fraud and abuse in the home health industry. The announcement includes the first-ever moratorium on the entry of any new home health agencies into Medicare; new regulations that will tighten the certification process; and, a doubling of the number of home health agency audits performed as part of the Medicare Integrity Program (MIP). This is the latest of the administration's initiatives aimed at fighting fraud in the home health program which served nearly three and one-half million Medicare beneficiaries in 1995.

A THREE-PRONGED ATTACK

Calling Time Out. The moratorium on new home health providers is a dramatic and *unprecedented* action demanded by the presence of waste, fraud and abuse in this relatively new industry. It was first recommended by the HHS Inspector General in her report on problems in the home health care business. This temporary hold will allow the Health Care Financing Administration (HCFA) to implement important new safeguards included in the budget; and will give HCFA time to develop new regulations.

Homing In on Fraud. The new regulations, along with administrative changes HCFA will impose, will make it easier for Medicare to weed out those who would bilk the system for their own profit at the expense of the most vulnerable population Medicare serves. Other, tough new standards HCFA will propose include:

- **Subsidiaries Can't Be Hidden.** Information about related businesses owned by home health agencies now must be revealed. This will help prevent home health agencies from hiding illegal activities by running transactions through subsidiaries or shadow companies that don't really exist. The Senate Aging Committee recently heard testimony from one former owner of a Georgia home health agency, who is now in prison, who used subsidiaries to defraud Medicare of \$16.5 million.
- **Frequent Recertification.** Periodic re-enrollment of home health agencies every three years. This proposed rule will help HCFA target abusive providers employing inappropriate practices. Independent audits of home health agencies' records will also be required by HCFA at the time of re-enrollment, and they must be done at the agencies own expense, the way banks are now required to do.
- **Agencies Must Have Experience.** A minimum number of patients must already be on a home health agency's rolls prior to seeking Medicare certification. This requirement helps establish an agency's experience in the industry before serving Medicare enrollees.
- **Financial Stability Assured.** Surety bonds of \$50,000 must be posted by home health agencies before they will be certified as Medicare providers. This new rule was part of the bipartisan budget agreement and helps establish the financial stability of new providers. Initial capitalization sufficient to operate for at least three months will also be required.

Increasing Audits to Weed Out Fraud. HCFA will increase its spending on home health audits by \$10 million—doubling the number performed from 900 to 1,800. The agency will also increase claims reviewed by 25 percent from roughly 200,000 to as many as 250,000. HHS' Inspector General has also received \$70 million in new fraud fighting funds from the Health Insurance Portability and Accountability Act that will increase investigations, prosecutions and audits of health care fraud and abuse—bolstering the efforts of Operation Restore Trust.

BUILDING ON PREVIOUS CLINTON ADMINISTRATION ACTIONS

Since taking office, President Clinton has made combating fraud and abuse in health care a major priority. The administration has increased the number of health care fraud convictions by 240 percent between FY 1992 and FY 1996, saving the taxpayers more than \$20 billion. The administration also launched Operation Restore Trust, an anti-fraud initiative targeting home health, that has identified \$23 of overpayments for every \$1 invested. In 1996, the President signed the Health Insurance Portability and Accountability Act into law which

expanded ORT and created the first stable source of funding for fraud control. The President has also just signed an historic balanced budget law that adds 10 years to the solvency of the Medicare Trust fund and gives HHS new tools for fighting waste, fraud and abuse. Those new tools include the power to bar felons from Medicare, the right to require providers to report their Social Security and Employer Identification numbers so that HCFA can determine if they have committed health care fraud in the past.

DRAFT Qs&As

On Home Health Agency

Moratorium Announcement

Q WHY IS THE DEPARTMENT IMPOSING THIS MORATORIUM ON NEW HOME HEALTH AGENCIES?

A There is an urgent need to make fundamental changes in the way Medicare does business with home health providers. We are imposing this moratorium so that the agency that runs Medicare and Medicaid can turn its attention from processing the 1,000 home health applications it gets every year to writing new regulations to fight fraud and abuse. This moratorium is unprecedented, it was recommended by the Inspector General and it is being imposed while the Department implements the new program safeguards included in the budget. During this time, the Health Care Financing Administration will write important new requirements to strengthen the provider enrollment process to better screen out problem providers before they are allowed to serve Medicare beneficiaries. These new regulations will also make it easier to expel problem providers in the future. We simply decided to call a halt to processing these requests while we toughen standards.

Q HOW LONG WILL THE MORATORIUM LAST?

A About six months, while the regulations are being prepared.

Q WHERE DOES THE AUTHORITY TO IMPOSE IT COME FROM?

A Under the law, the Secretary has the responsibility to ensure the fiscal soundness of its care providers. The Department currently receives about 1,000 applications per year for home health agency certifications.

Q WILL THIS MORATORIUM HURT BENEFICIARIES?

A The Department will work with existing home health providers to assure that no beneficiary goes without needed care during this temporary moratorium. There are so many certified home health providers across the nation, it is doubtful that any beneficiaries would face a problem.

Q WHAT WILL THE NEW REGULATIONS DO?

A The new regulations will make many important changes in requirements for home health agencies that want to participate in Medicare. Some of those changes will be:

- a new requirement that home health applicants supply business information about related organizations it may own. Often, home health agencies wishing to commit fraud can hide illegal activities by running transactions through subsidiaries or shadow companies that don't really exist. This new requirement will make those kinds of scams harder to commit.*
- a new requirement for periodic re-enrollment and/or certification of home health agencies every three years. This will help HCFA target providers with inappropriate practices or program abuses.*

- a home health agency will also be required to submit an independent audit of its records to HCFA at the time of re-enrollment. And, those agencies will have to pay for those audits, just like banks are required to do.
- a requirement that home health agencies serve a minimum number of patients prior to seeking Medicare certification. Some exceptions to this rule will be allowed.
- implementation of a new rule approved in the budget to require home health agencies to have \$50,000 surety bonds. This will establish the financial stability of new providers.
- A related new requirement will set initial capitalization requirements for home health agencies sufficient to operate the business for the first three to six months of operations.

Q WHAT ELSE IS HCFA DOING TO GUARD AGAINST FRAUD?

A We are doubling the number of home health audits and increasing claims reviewed by 25 percent. We will also be seeking more funds to increase our fraud surveillance by even larger numbers.

Q WHAT ELSE HAS HCFA DONE TO ACT AGAINST THE 'PROBLEM PROVIDERS' IN THE HOME HEALTH INDUSTRY IDENTIFIED BY THE INSPECTOR GENERAL?

A During the past two years, HCFA has taken action to deal with many of the providers identified as "problem providers" by the IG. Of the 698 home health agencies identified in a recent report, for example, HCFA had already taken action against the vast majority of them, including:

- terminated 67;
- referred an additional 75 to law enforcement; and,
- collected overpayments from 437 agencies.

In addition, one was convicted as an individual and four others as members of a convicted national company. HCFA continues to scrutinize carefully all of the remaining identified providers to determine appropriate action.

Q WHAT ABOUT THE CONDITIONS OF PARTICIPATION REGULATIONS?

A The comment period on the proposed COP regulations has closed and HCFA is reviewing the comments it received. We expect to publish the final rule during the moratorium. The COP rules will be complementary to the new enrollment regulations in improving service and service providers for home health recipients. The COP rules will require providers to be much more responsible for the quality and continuity of care patients receive. The COP rules will require providers to perform standardized assessments of the results (outcomes) of the care they have provided through the OAIS or Outcomes Assessment Information Set. OAIS will for the first time allow HCFA and ultimately patients to compare, on a level playing field, one home health agency to another. The COP will also require that patients be given more information on their treatment plan, in advance of care, and that agencies perform criminal background checks on job applicants.

Q IS THE HOME HEALTH PROGRAM "OUT OF CONTROL" THE WAY THE HHS DEPUTY INSPECTOR GENERAL HAS SUGGESTED?

A *At the time this administration took office, fraud in the home health industry was "out of control." But, we have made great progress since that time. Certainly, it was at an unacceptably high level, which is why we have taken this action today and why President Clinton has made fighting fraud a top priority since the beginning of his first term.*

The President's first budget closed loopholes in Medicare and Medicaid that had allowed waste, fraud, and abuse to occur. And in 1993, the Attorney General put fighting health care fraud at the top of the Justice Department's agenda. Through increased resources, focused investigative strategies and better coordination among law enforcement, the Justice Department increased the number of health care fraud convictions by 240 percent between FY 1992 and FY 1996 and we've saved taxpayers more than \$20 billion.

To build on these efforts, two years ago, we launched Operation Restore Trust, a comprehensive anti-fraud initiative which target home health care, in 5 key states. Since its inception, Operation Restore Trust has returned \$23 for every \$1 invested. In 1996, the President signed the Health Insurance Portability and Accountability Act into law, for the first time, creating a stable source of funding for fraud control. We've now expanded Operation Restore Trust and upgraded a toll-free hotline, 1-800-HHS-TIPS.

We will continue our work to reduce fraud and abuse in home health care with the proposals in the budget— such as giving us new authority to bar felons from Medicare and Medicaid; eliminating unnecessary payments to home health providers that make home health market a magnet for fraud; and moving to a payment system that will rein in home health providers' ability to bill Medicare without limit.

Q HOME HEALTH SEEMS TO BE JUST THE TIP OF THE ICEBERG. HOW DO YOU ACCOUNT FOR THE \$23 A YEAR BILLION IN INCORRECT PAYMENTS UNCOVERED RECENTLY BY THE HHS INSPECTOR GENERAL? WHAT IS YOUR ADMINISTRATION DOING TO CORRECT THIS PROBLEM?

A *In addition to fighting fraud, we have a comprehensive plan to fight waste as well. One quick way to get at wasted dollars is to institute new competitive models into our system. We will be exploring competition among health plans and competition among suppliers from whom we buy our goods and services. No longer will we waste dollars by paying ridiculous prices for things like wheel chair pads. The budget gave us clear authority to introduce competition into Medicare and we will quickly do so. Also, the budget will help us stop waste in home health by requiring agencies to bill at the rate for the area in which the service occurred (the patient's home) and not the rate the applies to the urban area where many agencies are headquartered. Also, the budget gives the Secretary new authority to reduce payments for goods and services that are inherently unreasonable up to 15 percent a year, or 45 percent over three years. That will significantly reduce waste in the program.*

Also, the independent audit that the Secretary announced today is just one of several additional actions we will take over the next several months.

HOME HEALTH CARE: IMPROVING QUALITY, TIGHTENING STANDARDS

Overview: Home health care, available to any home-bound beneficiary who requires skilled care, is the fastest growing expense in the Medicare program. This rapid expansion began in 1989, when a lawsuit forced changes in the Medicare regulations expanding eligibility and eliminating the cap on the number of visits. In 1996, more than 10 percent of Medicare beneficiaries received home services, at a total cost of \$18 billion. About 9,000 home health agencies currently serve Medicare beneficiaries. The rate of growth in the number of home health providers has slowed in the past year as the screening process has improved.

The Clinton Administration is committed to ensuring that Medicare beneficiaries get home care that is appropriate and of the highest quality. The administration is also committed to assuring that the home health program is free of the fraud that has become prevalent recently. As the result of the administration's increased scrutiny of this program, several reports by the HHS Inspector General have found that fraud is an increasing problem in this industry. In keeping with President Clinton's "zero tolerance" policy he has just announced the first-ever moratorium on admission of any new home health agencies into the Medicare program.

During the moratorium, the Health Care Financing Administration will implement the many new program safeguards won in the bipartisan balanced budget and develop new regulations aimed at greater fraud control. HCFA will also immediately implement several administrative rule changes.

These changes (outlined below) are in addition to other proposed rules already in the regulatory pipeline. On March 5, 1997, HHS announced two new proposed rules resulting from a comprehensive three-year evaluation of Medicare's home health benefit. One rule would revise Medicare's Conditions of Participation that home health agencies must meet in order to participate in the Medicare program, including requiring all home health agencies to conduct background investigations for all employees. A separate rule would require home health agencies to use standard measurements for the quality and outcomes of patient care. HHS is now considering comments and soon will publish final rules.

Under the new balanced budget agreement struck by President Clinton and the Congress, new tools to fight fraud and abuse have been given to the Health Care Financing Administration (HCFA). These measures will allow the agency to more effectively control the rapidly growing cost of home health benefits by moving to a prospective payment system, and separating Medicare funding for home health care into two streams: payment for care that follows hospital stays and payment for care related to chronic health problems. Separating these two very different types of home care will make it easier to determine when each is appropriate, reducing unnecessary care and payment for services that Medicare does not cover. Congress also approved the President's proposal to bar felons from participating in Medicare; eliminate periodic interim payments that were made in advance to home health agencies and justified at the

end of the year; require home health applicants to provide their Social Security number and employer ID number so that the agency can screen out those who have committed fraud in the past. HHS is also seeking to further reduce fraud and abuse in home health care, and other areas, by expanding the Operation Restore Trust pilot program to 12 states.

HHS has also just awarded more than \$2.25 million in grants for new programs to aid in the fight against fraud and abuse. The "Health Care Fraud and Abuse Control Grants" are funded by the Health Insurance Portability and Accountability Act (HIPAA), signed into law last August by President Clinton. More than \$1.5 million will be administered by the Health Care Financing Administration which runs the Medicare and Medicaid programs, along with the Department of Justice. The HHS Administration on Aging will administer the other \$750,000 which will be in the form of grants to state offices on aging. The grants will help expand the highly successful "Operation Restore Trust" mentioned above.

PROVIDER ENROLLMENT REGULATION

This regulation, together with administrative changes, would tighten the screening process for home health providers and make it tougher for problem providers to enter the Medicare program. Requirements would include:

Administrative Changes

- A requirement that home health agencies serve a minimum number of patients prior to certification. Exceptions will be considered so as not to adversely affect access to services in rural or urban settings.
- Data on related businesses owned by the home health agency must be shared with HCFA. This new rule will help prevent unscrupulous operators from running illegal transactions through subsidiaries or shadow companies that don't even exist.

Implementing the Budget

- HCFA will publish an interim final rule implementing a provision of the 1997 Balanced Budget Act to require home health agencies to obtain surety bonds of at least \$50,000. This rule will be published to meet the statutory deadline of Jan. 1, 1998.
- Initial capitalization requirements will be published mandating home health agencies have sufficient cash to meet operating expenses for the first three to six months of operation.

Notice of Proposed Rulemaking

- A *Federal Register* notice will be published outlining HCFA's plan to require periodic re-enrollment of home health agencies every three years. This would help HCFA to target providers who have abused the program or those with inappropriate business practices. A home health agency will also be required to submit an independent audit of its records to HCFA at the time of re-enrollment.

Increased Administrative Efforts

- HCFA will increase spending in the Medicare Integrity Program by \$10 million to double the number of audits performed from 900 to 1,800 in 1998. The agency will also increase the number of claims reviewed to 50,000 a year—a 25 percent hike over 1996.
- HCFA will seek additional resources, through the 1998 supplemental, for audits and medical

review as well as for implementation and enforcement of the new enrollment regulations.

CONDITIONS OF PARTICIPATION

Conditions of Participation are federal standards that home health agencies must meet in order to participate in the Medicare program. The rule proposed by the Clinton Administration to revise these standards would take several steps to protect beneficiaries and improve quality. These include:

- Requiring that home health agencies conduct criminal background checks of home health aides as a condition of employment;
- Expanding the current home health aide qualifications to include nurse aides who have completed appropriate nurse aide training or competency evaluation requirements;
- Requiring home health agencies to provide their staffs with continuous feedback on qualifications and performance as part of their continuous improvement programs;
- Requiring home health agencies to discuss with patients the expected outcomes of care so that patients can be more involved in planning their own care; and
- Requiring home health agencies to coordinate all care prescribed by physicians for their patients. Now, several agencies can serve one patient without the coordination that is needed to assure quality.

THE OUTCOMES AND ASSESSMENT INFORMATION SET (OASIS)

A second proposed regulation announced by HHS on March 5, 1997, would require home health agencies to use a standardized system called OASIS -- the Outcomes and Assessment Information Set -- to monitor patients' conditions and satisfaction. Under OASIS, home health care agencies must perform a standardized assessment of new patients within 48 hours to determine immediate care and support needs. Home health care agencies are then required to update this initial assessment continuously until a patient is discharged to reflect changes in the patient's condition and to measure patient and family satisfaction. Agencies must also evaluate the results of OASIS assessments and apply this information to agency practices as part of their continuous quality improvement programs. This standardized measurement system helps both inspectors and agencies to identify opportunities to improve performance and patient satisfaction.

FIGHTING FRAUD AND ABUSE

As the fastest growing expenditure in the Medicare program, home health care has become a frequent target of fraud and abuse. In fact, the newly issued report by the Inspector General on home health agencies revealed that in four of the five states reviewed by the IG as part of ORT, 40 percent of Medicare payments for home health should not have been made. These improper payments resulted in losses of approximately \$2.6 billion over a 15-month period. Stamping out this fraud and abuse is a top Clinton administration priority, and the administration's Operation Restore Trust initiative has produced dramatic savings since its inception in 1995. One thing Operation Restore Trust does is train state surveyors who review home health agencies to look for care being provided that is not covered by the Medicare program. Operation Restore Trust has now been expanded to 12 states. In addition, several key administration proposals to fight fraud have been included in the balanced budget bill, including:

- new penalties for kickbacks. Providers who pay kickbacks to induce referrals would be subject to civil monetary penalties of \$50,000 per violation.
- authority to require health care providers applying to participate in Medicare and Medicaid to

provide their Social Security numbers and their employer ID numbers so that the agency can screen out those who committed fraud in the past.

- authority to require surety bonds of \$50,000 from home health agencies and other providers so that fly-by-night operations never get into the program.
- a clear definition of skilled services so that home health agencies can no longer pad their bills for unnecessary services when a patient simply needs blood drawn.
- authority to deny payment to agencies that bill for far more services than other agencies do in similar situations. The authority goes beyond just home health providers and can be applied to any Medicare provider.

CONTROLLING GROWTH THROUGH APPROPRIATE PAYMENTS

The President's FY 1998 budget included several proposals to reduce the cost of Medicare home health benefits by \$14 billion over 5 years while reorganizing the way Medicare pays for home health services. Provisions passed by Congress and signed into law August 5, 1997 include:

- authority to establish a prospective payment system for home health services, to be implemented Oct. 1, 1999. Moving to a PPS system will be a tremendous tool to stemming the flow of home health care dollars. Instead of open-ended billing, HCFA will set, in advance, what it will pay for a unit of service, how many visits will be included in that unit and what mix of services will be provided. Providing questionable services will no longer be profitable.
- authority to bar felons from ever participating in Medicare again.
- Separation of home health services into two distinct benefits under Medicare Part A and Medicare Part B.
- a clear definition of limits on hours and days that home health care can be provided.
- elimination of periodic interim payments that were made in advance to agencies and not justified until the end of the year (part of moving to a PPS system).
- billing by location of service rather than location of the agency's headquarters. This will stop agencies from getting higher urban reimbursement when, in fact, the service occurred in a lower-cost rural setting.
- establishment of guidelines for the frequency and duration of home health services. Payments would be denied for visits that exceed the established standard.
- clarification of the definition of part-time or intermittent nursing care.

###

Proposals made to Senators Grassley & Breaux
to be discussed at their
Home Health Care Roundtable
September 25, 1997

DETECTION

- I. Program Controls
 - A. Beneficiaries
 - B. Providers
 - C. HCFA: structural changes to benefit

- II. Certification
 - A. Providers
 - B. States
 - 1. Initial certification surveys
 - 2. Recertification surveys
 - 3. Laws & regulations

- III. Accountability (Review process)
 - A. Beneficiaries
 - B. Providers
 - C. HCFA & Fiscal intermediaries

PROSECUTION

- IV. Enforcement

- V. Appellate Process

DETECTION OF FRAUD, WASTE & ABUSE

I. Program Controls

A. Beneficiaries

- Clarify the rules and regulations that govern eligibility for home care services under both Medicare and Medicaid.
- Educate beneficiaries about eligibility requirements.
- Empower consumers to help identify and fight fraud through information dissemination and financial incentives.
 - financial rewards
 - triple damages
 - qui tam provisions
 - 1-800 numbers
 - web sites
- Improve eligibility determinations and the approval of plans of care and services by providing additional guidance regarding the **definition of homebound**.
- Include adult day care centers in the definition of homebound.

B. Providers

- Create incentives to be efficient in the delivery of services.
- Improve **physician supervision** by requiring all patients to be seen on a regular basis.

PROPOSALS MADE TO SENATORS GRASSLEY & BREAUX TO BE DISCUSSED AT ROUNDTABLE

- Require more focused medical reviews with interviews to verify the need for services.

C. HCFA: Structural changes to benefit

- Establish a "gatekeeper" position to verify whether patients continue to need the care that is being provided.
- Introduce the use of a **case management agency** to eliminate the financial conflict of interest that currently allows the same home health agency to both (1) determine the need for care and (2) provide that care.
- Create an **accreditation system** for home health executives so that they are fully aware of Medicare reimbursement policies.
- Require **social security numbers and employee identification numbers** when applying to become Medicare providers.
- Establish a **moratorium** to stop the expansion of new home health care providers.
- Develop **outcome-based measurement systems**.
- Initiate **prior authorization** of all further home health services after a certain cap is met on each patient.
- Develop a **cap** for Medicare home health services; when a patient reaches the maximum allowed, the physician should be required to conduct a comprehensive assessment and medical review of the patient's condition and needs before any further home health services are authorized.
- Simplify regulations addressing reimbursable and allowable items under Medicare.
- Require **detailed codes** on each home health bill that identify the specific services provided (similar to the Physicians' Current Procedural terminology and the HCFA Common Procedure Coding System now used to identify many specific services billed to Medicare).

PROPOSALS MADE TO SENATORS GRASSLEY & BREAUX TO BE DISCUSSED AT ROUNDTABLE

- Do/Do not require **user fees** for survey and certification activities.
- Require the **collection of data and information exchange** related to both organizations and key persons of the organization.
- Further restructure the payment system to eliminate inappropriate incentives which unnecessarily increase cost and utilization. Additional options include: visit caps or limits, cost limits per beneficiary, benefit targeting, limits on expenditures per beneficiary, and beneficiary copayments.
- Reform the payment system in a way that will tie payment to both **patient acuity and desired outcomes**.
- Do not reduce existing **cost limits**.
- Institute/Refrain from instituting any **cost-sharing** by beneficiaries for home care services.
- Replace the cost-reimbursement system with a system of **competitive bidding**.
- Allow **home care referral agencies** access to the Medicare market for long-term and post-acute.

II. CERTIFICATION

A. Providers

- Prevent unscrupulous providers from gaining entry into the program.
- Strengthen the initial Medicare certification process.
- Establish comprehensive guidelines for initial certification that have stringent standards on
 - (1) **character**,
 - (2) **competence**, and
 - (3) **financial feasibility**.

PROPOSALS MADE TO SENATORS GRASSLEY & BREAUX TO BE DISCUSSED AT ROUNDTABLE

(1) **Character**

- Institute criminal background checks for all Medicare provider owners and administrators and prohibit entry of known felons into the Medicare program.

(2) **Competence**

- Require that providers have knowledge of reimbursement requirements before they become providers and require that providers continue to be aware of such requirements in order to continue to participate in the Medicare program.
- Require prior health care experience.
- Require that providers demonstrate proficiency by performing at a specified level before certification.
- Establish stricter standards regarding management behavior

(3) **Financial feasibility**

- Establish capitalization requirements, ensuring that providers are financially sound prior to certification.
- Establish stricter standards regarding financial behavior.
- Institute an application fee which would pay for costs of surveys.

B. States

(1) **Initial certification**

- Look at a history of operational performance when surveying for certification, i.e., later initial surveys.

PROPOSALS MADE TO SENATORS GRASSLEY & BREAUX TO BE DISCUSSED AT ROUNDTABLE

- Institute surveys that go beyond paper and include visits to patients receiving care.
- Train surveyors regarding reimbursement and coverage issues.
- Utilize a machine readable, sworn **questionnaire** to collect data used in evaluating applicant organizations and require states/localities to use this collected data in their evaluation process.

(2) ***Recertification surveys***

- Strengthen the recertification process & eliminate present weaknesses by requiring **periodic demonstrations of compliance** w/ all of Medicare's conditions of participation.
- Review all of a home health agency's **branch office operations** when conducting surveys.
- Institute **earlier and more frequent surveys** for home health agencies experiencing rapid growth in order to detect potential problems.
- **Revisit** home health agencies to verify implementation of corrective action plans.
- Require that state surveyors include **compliance-like studies** in their certification review process.

(3) ***Laws & regulations***

- Encourage **uniformity** among licensure laws and implementing regulations through the creation of model laws and regulations which the states can review for guidance.

III. ACCOUNTABILITY

A. Beneficiaries

- Require beneficiaries to sign a document certifying that home health care services have been provided.

B. Providers

- Require that all senior managers of home health care providers (i.e., CEO, CFO, and COO) certify the accuracy of cost reports prior to their submission to Medicare in order to ensure greater internal accountability.
- Enhance consumer protections for home health care recipients by strengthening federal requirements for worker screening and by creating quality assurance standards regarding training, supervision, and the practice of delivering in-home services.
- Require/Do not require abusive providers to pay for follow-up audit work.

C. HCFA & Fiscal intermediaries

- Refine methods and increase funding for fiscal intermediary review of billing to identify aberrant patterns early for education or intervention.
- Commit greater resources to enable review of a larger percentage of claims in a timely fashion.
- Educate auditors regarding Medicare reimbursement and areas of concern in order to identify improper reimbursement practices.
- Encourage continuity and consistency in assigning auditors to home health agencies to create an institutional knowledge regarding particular providers.

PROPOSALS MADE TO SENATORS GRASSLEY & BREAUX TO BE DISCUSSED AT ROUNDTABLE

- Require more interviews with direct in-house managers and institute concurrent reviews (i.e., more in-home random spot checks and hands-on audits).
- Look at the **overall structure of a business**, including related, outside for-profit companies. Do not restrict auditing to the home health agency alone.
- Institute an **integrity review** to be conducted in conjunction with financial statement audits.
- Encourage increased communication sharing between state survey agencies and regional home health intermediaries (cooperation).
- **Coordinate government reviews** of home health agencies to reduce the present paperwork burden by instituting an information-sharing system.
- Encourage stronger **local/state accountability** and stronger local clinical management to ensure that a high quality of care is provided to patients.
- Require a **public notice of survey results or billing information** of each provider.
- Discontinue the practice of issuing an explanation of Medicare benefits. If continued, it should be accompanied by an aggressive educational process to encourage beneficiaries and their families to take a more active rôle in policing the health care provided to them.

PROSECUTION OF FRAUD, WASTE & ABUSE

IV. Enforcement

- Create a **strike force** to attack recognized fraudulent providers.
- Institute a **permanent exclusion** penalty for home health agencies that are repeatedly cited for serious deficiencies.
- Clarify standards for the imposition of **intermediate sanctions**.
- Provide **additional administrative funding** to Medicare contractors to effectively combat fraud and abuse and carry out basic claims processing.
- Institute mechanisms to **terminate Medicare payment prior to prosecution** or other resolution of a health care fraud case.
- Establish **automatic liens** to preclude providers from disposing of property or assets when under investigation and fleeing the state.
- **Disallow any gain/benefit from the sale** of a home health agency if a provider has been excluded from the Medicare program or convicted of fraudulent activity.
- Encourage states to establish civil **qui tam** provisions and empower private citizens to bring qui tam actions for illegal remuneration, false claims, misrepresentations or illegal acts on behalf of medical assistance programs.
- Preclude the **discharge of Medicare debts** through bankruptcy.

V. Appellate process

- Exclude providers from representing the beneficiary in any appeal action.

PROPOSALS MADE TO SENATORS GRASSLEY & BREAUX TO BE DISCUSSED AT ROUNDTABLE

- Mandate that Administrative Law Judges (ALJs) are bound by HCFA manual guidelines and by model, regional, and local medical review policies.
- Reform the appeals process for claim denial and survey/certification deficiencies.
- Implement an informal cost report reimbursement appeal procedure.
- Protect responsible providers and the patients they serve with due process for providers including equitable intermediate sanctions and a functional appeal process prior to decertification from the Medicare program.

UNITED STATES SENATOR • IOWA
CHUCK GRASSLEY

PRESS RELEASE

press@grassley.senate.gov

www.senate.gov/grassley

**Statement of Senator Chuck Grassley
regarding Home Health Care Roundtable
9-25-97**

We just finished a “roundtable” discussion focusing on how to combat waste, fraud, and abuse within the home health care area. We reviewed a list of proposals brought to us by various people interested in cleaning up home health care.

The list is truly a “laundry list” of everything including the kitchen sink. The meeting covered a lot of ground and was very productive. My staff and I got a comprehensive view of the proposals.

I want to make a couple of things clear right from the start. First and foremost, Senator Breaux and I are working together on this issue because we are both very strong supporters of home health. Home health care can help people live fulfilling lives at home, not in an institution. Further, it can be cost-effective for the Medicare program.

The bad providers in the system are causing skyrocketing costs that threaten the entire benefit. So let’s be clear that what Sen. Breaux and I are doing is protecting and preserving the valuable home care benefit. Our ultimate goal is producing legislation that is designed to protect and encourage the quality provider while eliminating the problem provider.

The second point I want to make is about the nature of today’s meeting. Today’s gathering was not about reaching consensus among the participants. Instead, today’s meeting was designed to solicit opinions from a broad range of experts on the numerous proposals that have been brought to our attention.

Finally, I want to make my last point very clear. No final decisions have been made concerning the legislation. The meeting today has been an immensely helpful step toward producing legislation. The first step was our groundbreaking hearing in July. Now we’ve sought additional expert advice.

Sen. Breaux and I will review what we’ve learned today and the written opinions submitted from anyone who is interested, and we’ll decide how to proceed. Until we and our staffs have a chance to review all of the materials, it is simply too early to say what the final product will look like.

The approach Sen. Breaux and I have taken to this important and complex issues is not a “quick fix.” We want a comprehensive solution that will preserve the home health benefit. We put together, in my opinion, an outstanding group of home health care experts. Their insight and willingness to share candid thoughts with us will, I hope, result in a quality piece of legislation.

CHUCK GRASSLEY

PRESS RELEASE

*** PRESS AVAILABILITY ***

FOR IMMEDIATE RELEASE

Monday, September 15, 1997

Contact:

Monte Shaw

202-224-5364

Grassley, Breaux Announce Press Availability Following Home Health Care Fraud Roundtable

Experts Called Together to Craft Comprehensive Fraud Fighting Legislation

Washington, DC-- Senators Chuck Grassley and John Breaux today announced they would hold a press availability following a roundtable discussion focused on combating home health care fraud. The availability will take place on Thursday, September 25, at 3:10 PM, in Room 708 of the Hart Senate Office Building.

Grassley and Breaux organized the roundtable following a hearing focusing on waste, fraud, and abuse within the home health care industry. The hearing revealed systemic abuse of the Medicare home health benefit by a small number of problem providers. Grassley and Breaux will use the roundtable to craft a piece of comprehensive legislation to attack all aspects of fraud, waste, and abuse based on ideas brought forward at the hearing and the roundtable. Following the discussion, all members of the roundtable will be invited to share their thoughts with the press.

Those attending the roundtable include: **George Grob**, HHS Office of Inspector General; **Leslie Aronovitz** and **William Scanlon**, General Accounting Office; **John Molesworth**, Federal Bureau of Investigation; **Linda Ruiz**, Health Care Financing Administration Program Integrity Group; **Roslyn Mazer**, Department of Justice; **Mary Ellis**, Wellmark, Inc. (fiscal intermediary); **Bobby Jindal**, Louisiana Department of Health and Hospitals; **Michael Costello**, Veterans Affairs Office of Inspector General; **George Fields**, Internal Revenue Service; **William Dombi**, National Association for Home Care.

WHAT: Press Availability on Home Health Care Fraud Roundtable
DATE: Thursday, September 25, 1997
TIME: 3:10 PM
LOCATION: Hart Senate Office Building, Room 708

###